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ABSTRACT

The Governor's Task Force on the Mental Health of Juvenile Offenders in the state of Pennsylvania conducted a statewide survey of facilities for the care, treatment, and rehabilitation of adolescents between 12 and 18 years of age. The Task Force surveyed mental hospitals, community-based services, private psychiatric treatment centers, youth development centers, private training schools, county detention homes, day treatment centers, and youth forestry camps throughout the state as well as innovative approaches used by other states. Recommendations made by the Task Force to implement the delivery of mental health services to juvenile offenders centered on: (1) pre-adjudication/predisposition mental health services available to the juvenile court system; (2) provision of ambulatory mental health services at youth development centers and similar programs; (3) decentralized maximum security beds for hard core offenders and secure decentralized psychiatric inpatient beds; (4) establishment of aftercare services and a professional unit liaison with the Office of Social Services; and (5) a review of existing laws affecting juvenile offenders. (Author/HLM)

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ED 185459

REPORT AND RECOMMENDATIONS OF THE GOVERNOR'S TASK FORCE ON THE MENTAL HEALTH OF JUVENILE OFFENDERS

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INTERESTED CITIZENS:

On behalf of the Task Force on Mental Health of Juvenile Offenders, I submit our final report.

The Task Force was charged to develop a plan to meet the needs of mentally ill juvenile offenders, and to survey existing resources which could be mobilized to meet this need. The membership included representatives of the judiciary, the legislature, psychiatry and the child serving professions, as well as ex-officio representation from the Attorney General and the Department of Public Welfare.

The Task Force members worked diligently over a six month period to gather information and develop a series of recommendations. They endeavored to make this report as realistic and concrete as possible in the hope that it will serve as the basis for improvements in the delivery of mental health care to juvenile offenders.

Inquiries concerning the report and recommendations may be directed to the following Office of Mental Health staff:

Robert P. Haigh, Deputy Commissioner
H. Allen Handford, M.D., Director
Children and Youth Services
Room 308 Health and Welfare Building
Harrisburg 17120

Sincerely,

Mary Ellen McMillen

MaryEllen McMillen, Chairman
Task Force on the Mental Health
of Juvenile Offenders

FEB 1 3 1980

DEDICATION

This Report is dedicated to the memory of Ken Neeley who worked closely with us on the Governor's Task Force.

Ken was a fine young man with a bright future. His contributions to our work were significant and always indicative of his deep concern for those less fortunate than himself.

Although he leaves us prematurely, he will live on in our thoughts and in the efforts to accomplish what we planned together.

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Preparation of this report was made possible through the generosity of Mrs. Phillip Kind.

SUMMARY OF THE TASK FORCE RECOMMENDATIONS

The following represents a summary of the Task Force's recommendations to implement the delivery of mental health services to juvenile offenders. The recommendations are more fully described in Chapter [illegible] within the body of the Report.

1. THE JUVENILE COURT SYSTEM SHOULD HAVE AVAILABLE TO IT PRE-ADJUDICATION/ PREDISPOSITION MENTAL HEALTH SERVICES FOR DIAGNOSIS, EVALUATION AND CONSULTATION FOR CHILDREN AND YOUTH.

2. AMBULATORY MENTAL HEALTH SERVICES SHOULD BE PROVIDED IN YOUTH DEVELOPMENT CENTERS, YOUTH FORESTRY CAMPS AND STATE-SUPERVISED JUVENILE FACILITIES.

3. A TOTAL OF 180 TO 210 DECENTRALIZED MAXIMUM SECURITY BEDS SHOULD BE PROVIDED IN THE YOUTH SERVICES SYSTEM FOR HARD CORE VIOLENT JUVENILE OFFENDERS WITH SPECIALIZED MENTAL HEALTH TREATMENT AND RESEARCH SERVICES AVAILABLE TO THEM.

4. A TOTAL OF 30 TO 50 SECURE DECENTRALIZED PSYCHIATRIC INPATIENT BEDS SHOULD BE ESTABLISHED IN THE MENTAL HEALTH SYSTEM FOR MENTALLY ILL JUVENILE OFFENDERS.

5. AFTERCARE SERVICES TO JUVENILE OFFENDERS WHO HAVE RECEIVED MENTAL HEALTH SERVICES IN EITHER THE YOUTH SERVICES OR MENTAL HEALTH SYSTEMS SHOULD BE THE RESPONSIBILITY OF THE COUNTY MH/MR PROGRAMS COORDINATED WITH THE FAMILIES AND RESPONSIBLE AGENCIES.

6. A PROFESSIONAL UNIT SHOULD BE ESTABLISHED IN THE OFFICE OF MENTAL HEALTH IN LIAISON WITH THE OFFICE OF SOCIAL SERVICES TO FACILITATE THE DEVELOPMENT AND IMPLEMENTATION OF THE MENTAL HEALTH SERVICES RECOMMENDED BY THIS TASK FORCE. THIS UNIT SHOULD EXAMINE SERVICE NEEDS AND MAKE RECOMMENDATIONS FOR DATA COLLECTION AND INSERVICE TRAINING IN BOTH SYSTEMS.

7. THE JUVENILE COURT JUDGES COMMISSION SHOULD REVIEW THE UTILIZATION OF THE EXISTING LAWS WHICH RELATE TO THE MENTALLY ILL JUVENILE OFFENDER.

Chapter I

INTRODUCTION

There is a significant but unnumbered group of emotionally disturbed juvenile offenders in Pennsylvania and other states. Typically they come into contact with State authorities because they have broken the law. These youths need more extensive treatment than either the Youth Services or Mental Health Systems currently provide. The adolescent whom the Youth Development Center feels it cannot help because of a lack of mental health services may be the same person the mental hospital feels it cannot handle because of a lack of security. Successful treatment and rehabilitation of these youthful offenders requires cooperation among the Mental Health and Youth Services Systems, the juvenile courts, county government, and ancillary agents. It is clear that neither the provision nor the overall integration of service is sufficient to minister effectively to the mentally ill juvenile offender.

This Task Force was established in part as a follow-up to the Task Force on Maximum Security Psychiatric Care which worked throughout 1977, and reported a series of recommendations to the Governor on December 9, 1977. Members of the Maximum Security Task Force recognized, however, that they had not fully addressed the problem of forensic mental health services. They had chosen not to deal with the issue of the mental health of juvenile offenders because of the complexity of the matter, time limitations, and the necessity of narrowing the scope of their inquiry. The Governor, and his Special Assistant for Human Resources, Milton Berkes, in seeking to implement the recommendations of that Task Force, agreed to the necessity of a follow-up effort focused on youth.

On June 21, 1978, Governor Shapp convened the Task Force on the Mental Health of Juvenile Offenders. The membership of this new Task Force was chosen to represent a microcosm of the many elements of the systems involved. It was plainly understood that rational communication is basic. Thus, the membership includes representatives of various youth and mental health services, the judiciary, the legislature, county government, and the mental health professions. The members did not reflect any partisan bias. It was hoped that the Task Force could furnish to the present and future Governors a document that delineates the scope of the problem, identifies and develops the issues, and offers modern and humane solutions.

The Governor convened the initial meeting of the Task Force on the Mental Health of Juvenile Offenders on June 21, 1978. He declared that "the special needs of the mentally ill juvenile offender cut across several levels of government and major program areas. Many of the mandates of current law, however, often work at cross purposes with th goals of appropriate therapeutic treatment." (See Appendix for Executive Order Number 1978-15.) The Governor charged the Task Force to:

a. Review in depth the past and present history of all Commonwealth programs to provide mental health treatment for juvenile offenders.

b. Develop a discrete definition of the mentally ill juvenile offender and project their service needs for the next five years in Pennsylvania.

c. Survey innovative approaches in other States to address this problem.

d. Review the legislative, judicial, and executive trends which have emerged in this field in Pennsylvania.

e. Review and assess existing plans and programs within the Department of Public Welfare that address this issue.

f. Recommend those legislative and administrative actions necessary to address comprehensively and with consistency the mental health treatment needs of the juvenile offender.

g. Pursue its responsibilities through hearings or other means as necessary. All hearings so held shall be open to the public.

The Governor appointed twelve people to the Task Force in addition to the Secretary of Public Welfare, the Attorney General, the Commissioner of Mental Health and the Deputy Secretary for Social Services to serve as ex-officio members. Ms. MaryEllen McMillen was chosen by the Governor as Chairperson, and the Department of Public Welfare agreed to provide staff support for the project.

As defined in the Executive Order, the Task Force included the following members:

Mr. Richard W. Coles
Director
Youth Forestry Camp No. 1

The Honorable David DiCarlo
Penna. House of Representatives

Mrs. Harriet Goldstein, ACSW
Associate Director
Association for Jewish Children of Philadelphia

Clarice Kendall, MSW
Crispus Attucks Center

The Honorable Edmund V. Ludwig
Judge, Court of Common Pleas of Doylestown

Ms. MaryEllen McMillen
Director
Berks County Mental Health Association

The Honorable Michael O'Pake
Senate of Pennsylvania

Mr. Ernest Powell
Director
Youth Forestry Camp No. 2

Mr. Gary Rossman
Pennsylvania State Association of County Commissioners

Ronald Sharp, Ph.D.
Director
Juvenile Court Judges' Commission

Meyer Sonis, M.D.
Professor
Child Psychiatrist
Western Psychiatric Institute and Clinic

Robert Switzer, M.D.
Superintendent
Eastern State School & Hospital

EX-OFFICIO MEMBERS

Mr. Aldo Colautti
Secretary of Public Welfare

Robert M. Daly, M.D.
Deputy Secretary for Mental Health
Department of Public Welfare

Mr. Gerald Gornish
Acting Attorney General

Mr. Gerald Radke
Deputy Secretary for Social Services
Department of Public Welfare

The Task Force on the Mental Health of Juvenile Offenders convened a total of eleven times. Individual members provided data and information concerning their fields of expertise. Questionnaires were sent out to other states to survey their approaches to the care of juvenile offenders in need of mental health care. In addition, the Task Force relied heavily upon reports, prepared by Harold Graff, M.D., Meyer Sonis, M.D., and others, which described the history, potential, and problems of the Youth Development Centers and mental health facilities. Staff compiled these reports, as well as the data from additional research to characterize the existing network of relevant services. The Task Force invited people concerned with children and youth to express their opinions in writing or in person, but because of lack of time, public hearings were not held. (See Appendix G for distribution list.)

The Task Force succeeded despite numerous constraints such as a lack of complete data, a relatively short six month life, and a limited budget, in completing the bulk of its assignment. The report is based in part upon the empirical findings of people who are familiar with the problems of mentally ill offenders, and in part upon a more systematic analysis of their situation. (Appendices include synopsis of pertinent studies by Harold Graff, M.D., Meyer Sonis, M.D., and others.)

The members recognized early in their deliberations that they would need to narrow the definition of the population being discussed, originally termed, "the adjudicated juvenile in State-owned or State-supervised facilities." They agreed that they required a clearer focus to serve as the basis for their conclusions. Thus, the following definition, suggested by Judge Ludwig, was approved: "An institutionalized adjudicated, delinquent, as defined by the Juvenile Act, whose behavior is so violent or inappropriate as to require an evaluation of his mental condition and either inpatient treatment in a mental health facility as a voluntary or involuntary patient under Act 143 or if not diagnosed as mentally ill, intensive treatment in a secure setting," (Adopted at the Task Force meeting of November 29, 1978).[1]

[1] *Secure setting refers to youth services facility.*

The Task Force realized that the group defined above represents only a narrow range within a continuum of children with compound problems. The case of the status offender, who is not classified as dependent by virtue of Act 41, was particularly compelling. Many of the issues and recommendations contained within this report are applicable to the dependent child. The Task Force also recognized that improvements need to be made in the work that is done with children and their families. Planning and consultation ought to begin in the pre-adjudication and evaluation stages and continue throughout the course of treatment and/or rehabilitation. Yet, because of the Task Force's limited time and mandate, these issues could not be fully addressed. Perhaps future administrations will devote attention to them.

The Task Force members committed themselves to meeting the December deadline so that they would leave a complete working outline to Governor Shapp and his successor. Every effort was made to make this report as realistic and concrete as possible in the hope that it will be used as the basis for improvements in the delivery of mental health services to juvenile offenders.

The report is structured so that it approximates the course which the Task Force followed. It presents a brief outline of the available resources, the major issues, recommendations, and an implementation plan. The Appendices include much of the data which informed the deliberations of the Task Force.

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Chapter II

DESCRIPTION OF AVAILABLE RESOURCES

The Commonwealth of Pennsylvania operates or supervises several systems for the care, treatment and rehabilitation of adolescents between 12 and 18 years of age. These systems are mandated by different legislative acts and are administered under distinct divisions of the Executive Branch, depending on the presenting situation. The Judiciary is responsible for the disposition of adolescents who are adjudicated as delinquents and the Department of Public Welfare is charged with providing or assuring appropriate social services. In addition, the DPW acts as the initiating agency for youths who are not placed by the courts. The decision for placement of an adolescent depends upon a combination of the nature of the initiating agency, the availability of appropriate facilities, and the individual's behavior or condition.

Within Pennsylvania, as well as in other states, changes in philosophy, law and funding practices have had an impact on the delivery of mental health and youth development services. There has been a recent emphasis on providing decentralized, community-based programs because of lower costs and the desirability of providing service or treatment near one's home. Existing institutions are being used to care for a different type of youth than they served in the past. State-owned facilities largely care for those youths who exhibit the most severe problems since the private sector generally serves those least difficult to manage.

Juvenile offenders are usually first identified and placed by the courts. There are 59 judicial districts in Pennsylvania. The President-Judge in each district periodically assigns judges to serve in the juvenile courts, except in Philadelphia and Allegheny Counties, where judges are appointed to Family Courts. The use of psychological screening and psychiatric diagnosis and evaluation varies from court to court and depends upon a variety of factors, such as the individual judges and other court personnel, the availability of resources, the nature of the offense, and the offender's history. In addition, probation officers, detention home staff and police frequently initiate requests that certain juveniles receive psychological examinations. Clearly the courts' ability to obtain preliminary diagnoses and recommendations for appropriate care is crucial to the successful treatment and rehabilitation of mentally ill juvenile offenders.

The Juvenile Courts' need for mental health services is increasing. In 1977, a total of 41,527 juveniles were processed through Pennsylvania's courts. Of these 1,221 received psychiatric attention and 2,364 received psychological examination. These figures may represent some duplication and include services sought by families as well as by the courts. The courts usually go to the Base Service Unit in their catchment area for psychiatric "work-ups," although a few detention homes retain psychiatric personnel. Base Service Units are mandated to supply this service, yet they are often reluctant to do so unless a particular court makes a contractual agreement. Judges must sometimes rely solely upon the social history supplied by a probation officer to determine the proper disposition for a given juvenile. The same situation applies to emergency and short-term psychiatric treatment except in Philadelphia, Bucks and Allegheny Counties, where "court clinics," funded by and associated with the courts, are available. Local mental health facilities frequently complain of insufficient funds, staffing, and other resources necessary to care for youthful offenders. (See Appendix E and F for innovative approaches to these problems, i.e., the Shuman Center and Jefferson Medical College Projects.)

If an individual is determined to be mentally ill, even if he has been found to be delinquent, he may be committed to a mental health facility. The mental health system in Pennsylvania is composed of three major components: the private, county, and State sectors. The Department of Public Welfare's Office of Mental Health and four Regional Offices supervise these sub-systems in varying degrees. The Office of Mental Health is responsible for the identification of mental health needs, Statewide program planning, and budget analysis and evaluation. In addition, it proposes regulatory and legislative change, and recommends program plans and the allocation of State funds to the Secretary of Public Welfare.

There are 19 State mental hospitals of which five contain adolescent units — Eastern State School and Hospital, Haverford, Norristown, Warren and Woodville State Hospitals. They are all located in either the Southeastern or Western Regions of Pennsylvania. Since it is difficult to get placements between the Regions, there is usually a shortage of such services in the Northeastern and Central Regions. These units have a combined capacity for 200 patients, though they are presently underutilized. The relatively small patient population is determined primarily by the inordinately high costs involved in the operation of

inpatient facilities and by legislation which mandates community-based treatment whenever possible. However, within limits, the State mental hospitals provide very good care. The typical treatment plan includes group or individual psychotherapy, chemotherapy and behavior management to help the emotionally disturbed adolescents. Their staffs, including psychiatrists, psychologists, nurses, psychiatric aides and social workers are skilled and well trained in the specifics of adolescent therapy. Most adolescent units incorporate school and recreational programs as part of the total therapeutic milieu. Family therapy and/or planning is usually stressed, where possible, to plan for the youths' eventual re-entry into the family and community. Thus, State mental hospitals are designed for those who require long-term inpatient treatment which community mental health facilities are neither equipped nor mandated to provide.

At present, State adolescent units are not staffed or built to provide secure inpatient care. Despite some exceptions, they primarily admit children and youth who are under 16 years of age. They are not designed to contain the older, violently aggressive, psychotic adolescents. Some of the adolescents are currently distributed among various adult wards in State mental hospitals. These youths could be served on adolescent units if current facilities and staffing were reinforced.

There are 41 community-based mental health/mental retardation units in Pennsylvania, which were created in response to the MH/MR Act of 1966. They serve the Commonwealth's 67 counties and are required to provide emergency care; outpatient, short-term inpatient, and partial hospitalization treatment; aftercare; consultation and education; training; and rehabilitation, information and referral services. These services are available to residents of the State's 86 catchment areas. Each catchment area contains a Base Service Unit that develops treatment plans, maintains records, assumes responsibility for continuing care and monitors planning with State facilities.

Despite mandates that MH/MR services be distributed equally according to the population, this is not achieved in practice. Both the range and quality of treatment are inconsistent throughout the State. It is widely conceded that MH/MR programs are more available in the urban, Southeastern and Western Regions. This situation may be attributed to the presence of major universities, the attractiveness of these areas to mental health professionals, funding considerations and a concentration of programs which facilitates a broader range of treatment.

In addition to the State MH/MR services, the Federal government, through the Department of Health, Education and Welfare, provides grants for the Community Mental Health Centers program. The CMHC Act was first passed by Congress in 1963 and was reaffirmed by amendment in 1975. There are 44 such centers in Pennsylvania and their functions are comparable to those specified by the State. The CMHC's are designed to be part of a comprehensive plan for all mental health services, although the desired level of integration has not been realized. These Federal funds are given primarily to private, nonprofit mental health treatment facilities, and include money for both construction and staffing on a declining basis. As with other mental health facilities, most of the CMHC's (70%) are located in the Southeastern and Western parts of Pennsylvania.

There are eight private psychiatric treatment centers within the Commonwealth that accept adolescents. These include: Eugenia, Friends, Horsham, Institute of Pennsylvania, Northwestern Institute, Philadelphia Psychiatric Center, Philhaven, and St. Francis Hospitals. Together they have a potential capacity of 180 beds. In many cases, these hospitals offer comprehensive therapeutic programs, with emergency, short-term primary and secondary, intermediate, and long-term tertiary care. Yet, despite the completeness of the private sector's offerings, it generally complements, rather than duplicates, the State mental health system. Only about 10% of the beds in private adolescent units are made available to adjudicated youths, and violent acting out juveniles are usually not admitted to these facilities. Further, the regional distribution of these units is even more biased than those operated by the State. All but two of the nine private hospitals are located in the Southeastern Region.

The Bureau of Youth Services within the Office of Social Services is responsible for youths who are found to be delinquent, and in need supervision, care and rehabilitation. This Bureau operates the State's Youth Development Centers and supervises the Private Training Schools and County Detention Homes. The Bureau of Child Welfare encompasses voluntary and public child welfare agencies, group homes and other similar facilities. The Social Services structure, including private, county and State components, parallels that of the mental health system. Of the youths who were processed by the courts in 1977, 3,775 (11.55%) were placed in public or private institutions for delinquency and other similar court ordered programs. This group consists primarily of socialized delinquents, though Youth Development

personnel report an increasing, yet undetermined, number of youths who manifest mental health problems in addition to delinquent behavior.

A juvenile offender enters the Juvenile Justice System following arrest, and may be held at a County Detention Home. There are 22 Detention Homes in Pennsylvania with a capacity for over 500 youths. They emphasize custodial care since their populations are highly transient. Some detention homes retain psychologists and social workers in addition to whatever community mental health services are available. They do not prepare in-depth psychological profiles as a rule except when requested, or when warranted by an individual's behavior.

Approximately 60% of the youths placed by the courts are sent to various group homes and similar state-supervised institutions. In the larger facilities juveniles are housed in cottages and small dormitories, usually supervised by a couple who serve as houseparents in return for their residence and a modest salary. Group homes generally contract for social workers and mental health professionals, either from private or county providers. The Commonwealth pays up to 50% of mental health costs for this group, which consists mostly of dependent and delinquent youths who are not considered to have major problems.

The next, more restrictive, type of accommodations for adjudicated juvenile offenders is the State-supervised training school. There are seven of these including Berks County Boy's Home, Gannondale School for Girls, George Junior Republic, Glen Mills Schools, New Life Boy's Ranch, St. Gabriel's Hall and Sleighton School. They have a capacity of about 740 beds with another 240 places for day supervision, compared to approximately 6,000 beds available in the group homes. The staffing is richer and the programs are more regimented, in accordance with the more confirmed delinquent behavior of the youths. In addition, all training schools have consulting psychiatrists; since the BSU's frequently do not want to become involved with these juvenile offenders.

The Youth Development Centers and Youth Forestry Camps represent the institutions for delinquent juveniles that the State operates. The six YDC's include Cornwells Heights, New Castle, Warrendale, Waynesburg, Loysville and the YDC complex at Philadelphia which is being phased out. The Youth Forestry Camps are located in Raccoon Creek, Hickory Run and Trough Creek State Parks. The entire system has a capacity of about 860 beds, of which 188 are located in "secure" units. Because of Act 148, which redefines how these services are to be financed, the YDC's are operating at only about 75% of their capacities. While the Youth Development System as a whole has witnessed a declining population, the secure units are virtually filled.

The YDC's are open institutions built on the cottage plan; the new institutions house 16 youth in a cottage. Each institution has a school on the campus, a central dining hall, a medical facility, indoor and outdoor recreation facilities and separate administration and maintenance buildings.

The YDC's combine treatment with daily living and thus the youths live, work and interact in groups or cottages with their own staff teams of youth development counselors and houseparents. This staff also maintains contact with the youths' teachers, families and probation offices. The length of stay is determined by the particular youth's progress, and his family and community situation. This period usually varies from 4 to 10 months.

The YDC's provide a range of social and vocational services aimed at the rehabilitation of the youths through correction of their delinquent behavior. They offer both custodial and rehabilitative services to juveniles in their care. Their intent is to protect the public welfare while providing a safe, nourishing atmosphere for the physical and mental development of youths committed by the courts.

The primary emphasis of the YDC's treatment programs is to encourage and reward a youth's efforts at making positive changes in his behavior and personality. The available support services include social casework, psychological testing, counseling, psychiatric consultation, academic and vocational education, medical and dental care and religious counseling. Since the goal of these services is the youth's successful re-entry into the community and sustained socially acceptable behavior, emphasis is also placed upon encouraging the youth to develop new or alternative methods of coping with family, peer and community interactions.

The Youth Development Programs vary according to the age and sex of their populations and according to the geographic location of the institution. Since most of the students are of average or dull-normal intelligence, educational and therapeutic programs are designed accordingly. They are not, however, targeted to serve juveniles who have an intelligence quotient lower than 70 or who have severe emotional and/or physical handicaps.

The isolated rural location of several of the Youth Development Centers has influenced the development of their programs. The lack of professional, clinical and vocational personnel, who are needed to meet the youth's specialized needs, is of particular concern. Also, treatment difficulties result from separating the youths so far from their families and communities. For example racially balanced staffs often cannot be recruited from rural locations.

Three Youth Forestry Camps are currently operating in Carbon, Huntingdon and Beaver Counties. They admit boys between the ages of 15 and 18. In the past these camps offered programs that were primarily work-related, but in recent years they have shifted to more treatment-oriented programs. While some conservation work in cooperation with the Department of Environmental Resources continues, more emphasis is placed on vocational, educational and therapeutic services. Youngsters are frequently placed in job locations in communities surrounding the individual camps.

Several YDC's have created separate Day Treatment Centers as adjuncts to their regular programs. A Day Treatment Center is a non-residential facility that can offer a variety of daytime programs for delinquent and deprived youths. Those who participate in the program may also be housed in residential centers but such centers are separate from the Day Treatment Center and licensed under the appropriate regulations.

Current Day Treatment Centers in Pennsylvania operate from 9 a.m. to 6 p.m. or 9 p.m., five or seven days a week. Some of the facilities have all their programs within a single physical location, providing school, recreation and counseling at that site. Others maintain a separate physical location only as a base of operations. Children may attend school or hold jobs in the community, with the Center serving as a central coordinating point.

To fulfill the task of surveying innovative approaches which other states use to meet the mental health needs of juvenile offenders, the Office of Mental Health sent out questionnaires to various states asking for information concerning their treatment of mentally ill adjudicated juveniles. Each of the states was specifically asked whether or not it treated mentally ill adjudicated juveniles in state-owned or operated institutions; the number of such facilities; whether these facilities were administratively assigned to mental health, corrections or some third category; whether any of the programs were considered to be innovative, and if so, to provide a description.

In most states, adjudicated juveniles with mental health needs are either mixed in with other, non-adjudicated juveniles in mental health facilities, or they receive ambulatory services while retained in youth correctional facilities. A youth's disposition generally involves a weighing of the need for mental health treatment against the need for secure incarceration. Ordinarily, a judge remains the arbiter in these decisions.

Several states have designed integrated programs in either mental health or correctional facilities, which provide both security and mental health care. Alabama, Missouri and Wisconsin maintain secure mental health units which primarily accept adjudicated juveniles. Others, such as Colorado and Washington, place mentally ill juvenile offenders in correctional facilities with mental health treatment capabilities.

Liaison positions are sometimes used to bridge the gaps between correctional and mental health systems. In Virginia a "Prescription Team" acts as liaison between the Departments of Correction and Mental Heath Retardation. In Texas, the court retains jurisdiction over youths who have committed crimes but are not adjudicated because of their need for psychiatric commitment.

Of all the programs designed for mentally ill adjudicated youth, perhaps the most innovative have involved the sharing of administrative responsibility between the relevant agencies. In Illinois, the Departments of Correction, Mental Health and Child and Family Services together administer such programs, but it is frankly admitted that this experiment has been an administrative nightmare. In New York City, the Court Related Unit represents a joint venture by the Department of Mental Hygiene and the Divsion for Youth. Staff from both units are responsible for screening the youths.

A tabulation of the data received from the several states which responded to the questionnaire is provided in Table I.

Questions asked for Adjudicated Youth Questionnaire:

1. Do you treat mentally ill adjudicated juveniles in state-owned or operated institutions?

   How many such facilities in your state?

2. Are these **mental health, correctional,** or **some third kind of facility?**

3 Do you consider any of these programs in your state innovative?

Summary of Data:

TABLE I (Continued)

State	No. Of Facilities	Patient Populations of Each Facility	Type (1)	Innovative Program
ALABAMA	3	39,20/90	M.H./Y.S.	Yes
ARKANSAS	2	30	M.H.	
CALIFORNIA	5	150/105	M.H./C	
COLORADO	3	50/25	M.H./C	Yes
DELAWARE	1	100	M.H.	
GEORGIA	8	35,10,20,13,22,23, 29,36	M.H.	Yes
HAWAII	2	3/60	M.H./C	
ILLINOIS		20	M.H./YS	Yes
IOWA	3	61,30,20	M.H.	Yes
MICHIGAN	8	125,12,162,60,60,60, 85,40	M.H.	Yes
MISSOURI	7	200	M.H.	Yes
NEBRASKA	2	40,18	M.H.	
NEW HAMPSHIRE	1	60	M.H.	
NEW JERSEY	0	250	M.H.	
NEW YORK	16	45,10,55,10,210,10, 114,75,40,20,36,20, 38,24,18,36,55,25,24	M.H.	Yes
OHIO	4	84,48,60,70	M.H.	
RHODE ISLAND	1	40	M.H.	
TENNESSEE	5	250	M.H.	Yes
TEXAS	—	—	M.H.	Yes
VIRGINIA	1	30	M.H.	Yes
WASHINGTON	2	16+	C	Yes
W.VIRGINIA	1	23	M.H.	
WISCONSIN	2	52,75	M.H.	Yes

South Dakota reported no state facilities

(1) Legend
M.H. = Mental Health
C = Correctional
Y.S. = Youth Services

Chapter III
MAJOR ISSUES AFFECTING SERVICE DELIVERY

1. Information Collection and Analysis

Statement of the Issues

The first issue addressed by the Task Force was the collection of adequate information concerning the nature and extent of mental illness among adjudicated juvenile delinquents. The members sought to obtain and analyze such data as was available in order to assess the numbers of youth involved, the type, nature and adequacy of available treatment services, and the changes needed to improve the current delivery system.

In the performance of its duties, the Task Force had several sources of information available. Those sources included two reports on the current institutional situation by an adolescent psychiatrist, psychological and psychiatric records at the nine State youth development facilities, limited data from the Office of Children and Youth's management information system and verbal reports from institutional directors and their direct care staff.

The available data base from these sources was known to be deficient both qualitatively and quantitatively; however, the Task Force concluded that findings and recommendations responsive to the Governor's charge could be made.

Issue Development

During the spring of 1977 the offices of Social Services and Mental Health arranged for Dr. Harold Graff to visit Youth Development facilities, talk to staff, review records, and write a report of his findings (See Appendix C). During that study Dr. Graff heard what others in the field have been hearing in the past few years, namely, unit staff describing the change in the type of admissions coming to them. The adjudicated youth, they claim, in increasing numbers seem to be more sociopathic, "colder," less remorseful, as well as more emotionally disturbed, manifesting more neurotic, withdrawn, depressed, or overtly aggressive behavioral symptoms. In addition, institutional staff frequently find that neither the courts nor the mental health facilities provide adequate diagnostic material upon which to base a sound treatment strategy.

Under current diagnostic programs, accurate numbers of emotionally disturbed youth in individual centers are difficult to ascertain. Some institutions reported high numbers of emotional disorders while others reported practically none. In some centers psychometric examination is an integral part of diagnostic workup and treatment planning, while in others psychological and psychiatric input is obtained only when a problem manifests itself. Thus, current problems may not be uncovered, or if a youth does show an overt problem, which comes into the open, staff may not have techniques for immediate intervention. What is available at present is a listing of those youths who have had previous hospitalization or treatment, which does provide a partial statistic on the problem.

2. Impact of the Laws and Judicial System

Statement of the Issues

It is essential to understand the laws and legal structure governing both juvenile delinquency and involuntary mental health treatment in order to understand the nature and operation of the systems dealing with the mentally ill juvenile offender. Often both sets of laws and both systems will apply to the same child. Because of this interrelationship, or interdependency, the law or legal structure resorted to may well depend on which system is the more accessible or the more convenient to use in a given instance. As a result, interpretation of the law may vary with the availability of facilities and services. Conversely, the use of one system in preference to another may vary with particular interpretations of the law. The impact of the laws and the legal structure on the mentally ill juvenile offender must be viewed in this light.

Issue Development

One highly significant factor in determining the institutional placement of behaviorally deviant children are the laws governing juvenile delinquency and mental health commitments. Presently a disturbed child whose behavior is aggresive or anti-social is likely to be adjudicated delinquent or dependent rather than mentally disabled. The likelihood becomes even greater where community services and hospital programs for such children are limited. Just as with the mentally ill adult who is incarcerated on a criminal charge, a child in need of mental health treatment may often be committed to a facility for delinquents or dependents. An ongoing tension has existed between the mental health and the delinquency or correctional systems based on the relative ease of procedural utilization and the availability of service. In recent years, court decisions have ruled that these systems may not be used interchangeably or as alternatives for each other, reasoning that different constitutional concerns and protections are applicable. The fact, for example, that a child may be detained as delinquent does not itself justify involuntary mental health treatment.

In Pennsylvania, section 29 of the Juvenile Act of 1972 (Act 333), in an important policy expression, directed that mentally ill children were not to be committed as delinquent, but all such cases should be diverted puruant to the Mental Health and Mental Retardation Act of 1966 (Act 6). The provisions of this law in turn authorized the involuntary commitment of all persons "in need of care and treatment by reason of mental disability." It also permitted parents to commit children under age 19, as a "voluntary" placement, with or without the child's consent. In 1971 by regulation of the Department of Public Welfare, a committed child over 12 became entitled to demand a hearing.

The Mental Health Procedures Act of 1976 (Act 143), which repealed section 29 of the Juvenile Act of 1972 as to the mentally ill, provided for parental voluntary commitments of children under 14 and for a child age 14 to 18 to have the right to commit himself subject to his parent's right to be heard. It left the law silent as to the disposition of mentally ill children who came into juvenile court. In April, 1978, this was rectified by an amendment (Act 53) to the Juvenile Act, now restated in the Judicial Code, directing that when a child is subject to Act 143 the court should proceed under the provisions of that Act. All mental health commitment procedures that did not guarantee a child a counseled hearing upon hospitalization have been held to be constitutionally deficient, and this question is now on appeal before the Supreme Court of the United States.

Because of the broad dispositional powers confered by the Juvenile Act of 1972 and the problems encountered in affectuating mental health commitments, juvenile courts, both before and after Act 143, sometimes ordered a child into a hospital under the juvenile law rather than the mental health law. And in some cases, these children were found not to be mentally ill.

In addition to making changes in procedure, Act 143 also raised the standard for involuntary commitment. It requires a showing of "clear and present danger" as evidenced within the past 30 days by acts showing dangerousness to self or others or prospectively within the next 30 days by a showing of the likelihood of physical decompensation unless adequate treatment is provided. This law which in many instances has been given an unnecessarily strict interpretation by those administering it — and which is still not fully or correctly understood — has increased the degree of difficulty in obtaining an involuntary commitment. Regulations promulgated by the Department of Public Welfare in September, 1978 allow a judge to approve the voluntary commitment of an adult who is detained on a criminal charge or serving a sentence upon professional certification of the need for mental health hospitalization. As yet, there is no parallel regulation for juveniles. In the past, the juvenile court has accomplished the same result by conditioning probation on the child's remaining in a hospital and participaing in treatment. In such instances, although its legal propriety has been questioned, the hospitalization is considered "voluntary"

and, therefore, does not need to meet the involuntary commitment standard. The juvenile court is also left in control of the child as compared with an involuntary commitment in which Act 143 gives the hospital superintendent the sole power to release.[2]

3. **The Current Service Delivery System**

Statement of the Issues

a. Service Availability

Mentally ill juvenile offenders are frequently placed inappropriately for several reasons. First, the State's five mental health programs for adolescent youths are not designed or staffed to treat aggressive or violent juveniles, nor does the private sector offer a useful alternative. Second, the diagnostic and evaluation services mandated by State regulations are not consistently or effectively provided.

b. Service Coordination

The inability of the mental health and youth services system to generate a consistent level of effective service coordination manifests itself in numerous.

i. Cooperation within the Department of Public Welfare's Mental Health and Social Services Systems at the State, regional and local levels, and the Department's relationship with the judiciary is currently inadequate to assure effective coordination of mental health and rehabilitative services for the serious juvenile offender.

ii. Having developed from very divergent bases, the mental health and youth services systems have inconsistent funding formulae and service access criteria which limit their ability to function cooperatively. As a result, the full array of mental health services available in the State is not being adequately utilized to diagnose and treat institutionalized juvenile offenders.

iii. Mental Health and Youth Services Institutions share a common need for continuous, systematic in-service training involving all relevant disciplines in the two systems where not sufficiently available.

iv. The State's relationship with mental health agencies in the private sector does not now include the purchase of residential services for the aggresive, disruptive youth.

v. The State does not adequately sponsor the participation of State-supported universities and colleges in research and development projects designed to generate innovative techniques and programs.

vi. The long-standing differences between the social service and judicial sector have not been approached in a manner conducive to the development of a level of agreement and cooperation beneficial to service delivery.

vii. There has been a reluctance to recognize that the body of knowledge and the skills required for the delivery of mental health services to mentally ill adolescents are quite different from those required for the operation of a correctional system; the goals of the two systems are not at all identical, and may in part be incompatible.

c. Service Accountability

Current DPW monitoring practices are often ineffective in identifying service gaps and initiating activities designed to implement needed changes.

[2] *Please see separate opinion distributed with this report.*

Issue Development

a. Service Availability

A Survey of the State hospitals indicates that there are five special programs for adolescents diagnosed as mentally ill. The largest is the Eastern State School and Hospital located in Bucks County. This is a treatment center for children and youth, ages 6-15, with a current population of 180. Besides this program there are four small units, at Haverford, Norristown, Warren and Woodville State Hospitals, providing additional bed capacity of 30 in the eastern half of the State, and 45 in the western part. While these programs have adequate and qualified professional staff complements, they are often operated with a minimum of nursing coverage, and are clearly unable to continue their current programs while attempting to serve court-committed aggressive, dangerous offenders.

There are indications that the State's mental health system fails adequately to serve children and youth who experience mental illness. In some cases the symptoms may subside due to spontaneous remission, or the person may be treated suucessfully as an adult. In other cases, the illness may linger and worsen, causing a personal and social toll that must be borne eventually by all.

With the closing of the State Correctional Institution at Camp Hill to juvenile commitments in August, 1975, a great deal of responsibility fell upon the youth development system to admit and treat serious youthful offenders. For this purpose, four alternate facilities have been developed: one each at the Cornwells Heights and New Castle Youth Development Centers, one on the grounds of the Allentown State Hospital, and another at the Harrisburg State Hospital. The capacity of these four units is now about 122, although the populations regularly exceed that by 20 or 30 youths. In January, 1979, another secure unit will open at the Danville State Hospital for 20 additional offenders.

Since these units constitute the deepest penetration into the juvenile justice system, with the next step being certification to adult court, and the nature and needs of these youngsters vary remarkably, the commitment patterns differ from one county to the other. Some youths have committed their first or second offenses while others have long histories of intensive antisocial involvement, and still others are clearly sociopathic.

Until now these special programs have struggled with limited success to develop techniques designed to prevent AWOL's and to provide educational and group living experiences radically different from the penal model. The psychological and psychiatric program aspects so essential to a portion of "borderline" or "dual-diagnosed" offenders have not yet evolved.

b. Service Coordination

i. Traditionally the two offices within the Department of Public Welfare which impinge upon the lives and treatment of the mentally ill juvenile offender have not devised inter-office liaison and communication required to facilitate their charges, and to guarantee systematic delivery of needed services to the small, but distinct, client group requiring both services.

It has become a common anachronism that psychological and psychiatric services at one State facility may be forced to operate in a severly delimited, if not primitive, mode, while a few miles away there exists an institute or university with renowned specialists using the latest in sophisticated resources and techniques. The youth Development Centers need expanded and improved mental health services because a larger proportion of their populations includes the deviant and disabled. The mental health professionals, especially the psychiatrists, are becoming increasingly interested and involved with the phenomenon of delinquency.

ii. Current fiscal and legal constraints often prevent the full utilization of

resources already available for the mentally disabled delinquent. Often mentioned is the situation in Bucks County where a Youth Development Center and the Eastern State School and Hospital, both of which often serve a similar client, co-exist side by side but virtually have no formal arrangements for the mutual exchange of service components. To some extent legal jurisdiction and client rights are involved, since a child should not be casually shuffled between programs involving Acts 335 and 143. But mutual arrangements which would benefit both programs are not beyond possibility.

iii. Personnel serving the mentally ill and the delinquent are natural allies since both client groups tend especially to manifest anti-social, deviant or unacceptable behavior of some kind. Both groups may do so in a benign, rather harmless manner, or an aggresive and dangerous way. Certainly, both professional groups serve the same client at different times as he wends his way from one program and agency to another. Yet, in this case too, the potential for synergistic interaction is neglected. Youth service personnel need and desire more and more knowledge concerning the psychological sciences and techniques, and mental health staff seek to improve their skills in managing disruptive behavior in accordance with the Department's Patient Abuse Regulations.

iv. Generally, private agencies are not involved in the treatment of serious, dangerous or mentally ill delinquents, but there are reasons to believe that such agencies could contribute their expertise to the problem if incentives to do so were provided.

v. Some programs have recently been implemented whereby medical colleges provide direct mental health services to adjudicated youth. These include the Shuman Center and Jefferson Projects, (See Appendix E and F) which respectively serve the Pittsburgh and Philadelphia area YDC's. However, research and development are not considered to be of prime importance in either case. Certainly, medical colleges are logical choices for such work, and it is felt that they should be more fully utilized to help improve the delivery of mental health services.

vi. There frequently has been a destructive adversarial relationship between youth services and the juvenile courts. Each sector has too often been ignorant of the needs and intentions of the other. Proper coordination demands meeting, consultation, and compromise, rather than each proceeding as though the other did not exist.

Chapter IV.
TASK FORCE RECOMMENDATIONS

After reviewing the current status of juvenile offenders with mental health needs in the Commonwealth and other states, as well as relevant legislative judicial and executive mandates, the Task Force's recommendations concerning the improvement of services for mentally ill juvenile offenders are presented.

These include:

Pre-Adjudication/Pre-Disposition Mental Health Services

The Juvenile Court system should have available to it mental health resources for diagnosis, evaluation and consultation for children and youth.

2. **Ambulatory Mental Health Services in YDC, YFC and State-Supervised Facilities**

   a. Ambulatory mental health services should be provided in both systems and should include diagnosis and evaluation, consultation and education, crisis intervention, and outpatient treatment.

   b. The regulations to Act 143 should be amended to state specifically that voluntary transfer applies to juveniles as well as to adults.

3. **Services for Hard Core Violent Juvenile Offenders Requiring Security**

   a. A total of 180 — 210 maximum security beds should be provided in the Youth Services System.

      1. The beds in the Youth Services System should be decentralized, there should be standards agreed upon by the Juvenile Court Judges Commission and the Department of Public Welfare as to which children are appropriate for those maximum security beds, and there should be specialized mental health services available.

      2. The recommendation of 180 — 210 beds is not in addition to the existing 188 security beds, but the latter beds do not fully qualify as the type of bed being recommended. The 188 beds should be upgraded to meet the standards required for both security and appropriate treatments.

   b. A group of professionals and non-professionals experienced in both juvenile justice and mental health should be appointed to research, propose and implement new treatment programs for the mentally ill juvenile offender. (The State's universities should be utilized for this purpose, in addition to other sources.)

4. **Services for Those Mentally Ill Juvenile Offenders Requiring Security**

   a. 1. Thirty to fifty secure psyshiatric inpatient beds should be established in the mental health system. Violent, agressive juveniles who are dangerous to others should not be co-mingled with mentally ill and non-violent juvenile offenders who require security. Programs appropriate as to sex should also be provided.

      2. These beds should be decentralized and there should be standards for admission agreed upon by the Office of Mental Health, the Juvenile Court Judges Commission and the Office of Social Services.

   b. Adequate provision throughout the Commonwealth should be made for non-secure, inpatient, adolescent treatment beds for such mentally ill juvenile offenders who may require these services. Particular attention should be given to the needs of the Northeastern and Central DPW Regions.

   c. Different types of service delivery possibilities, including such issues as administration, funding, size and location of program, and length and modality of treatment raise serious philosophical, practical and systems problems. The Task

Force has not been able to give these issues the consideration they deserve, but emphasizes their importance and the need for thorough study and analysis before any particular service delivery strategy is adopted.

5. **Aftercare and Coordination**

a. Liaison with families must be done during treatment. Discharge planning must include the family and the community (BSU and Juvenile Probation).

b. County Mental Health Programs should be responsible for mental health case management of all juvenile offenders who have received recommended mental health services in the juvenile justice system and are in need of aftercare and follow-up.

6. **Liaison Unit**

The Department of Public Welfare should provide a unit within the Office of Mental Health to function as liaison with the Office of Social Services. We believe this unit is necessary to help guarantee appropriate placement and services for mentally ill juvenile offenders, and to facilitate the development and implementation of mental health services recommended by this Task Force. This unit should examine service needs and make recommendations for data collection and inservice training in both systems.

7. **Review of Laws**

The Task Force recommends that the Juvenile Court Judges Commission review the utilization of existing laws that relate to the mentally ill juvenile offender.

Chapter V
IMPLEMENTATION PLAN

This chapter is organized in the same sequence as the Task Force Recommendations (Chapter IV). For each recommendation the following items are identified:

a. Actions to be taken.

b. Timetable.

c. Estimated Cost.

d. Responsibility Assigned.

In the summary section is a composite of the individual recommendations.

Overall Review and Implementation Strategy

The primary agenda of the Task Force once its formal work is completed, is that appropriate State and local agencies give serious and timely consideration to the recommendations contained herein. Should the ultimate decision be made to reject all or a portion of the recommendations, the Task Force asks that it be so informed through periodic monitoring reports from the Department of Public Welfare (Offices of Mental Health and Children and Youth).

Since this report is being issued at the point of change of Administrations, the Task Force will take several steps to present its recommendations for consideration.

1. A formal presentation to Governor Shapp takes place December 21, 1978, with concurrent release to the press.

2. The report will be simultaneously transmitted to the Governor-elect with the request to meet with him or his designee.

3. Within two weeks the report will be distributed to all persons on the Task Force mailing list and to the leadership of both Houses of the Legislature.

4. The staff member assigned from the Governor's Office of Human Resources to assist in preparation of this report, will remain in the Office of Mental Health for several months to coordinate distribution, develop and provide a concluding summary to the Task Force and handle any other activities arising from the termination of the group.

5. Once the new Secretary of Public Welfare is in office, the Chairperson of the Task Force will arrange a meeting to present the conclusions of the Task Force and to seek a formal Departmental plan and position.

Specific Task Force Recommendations

The cost estimates in the following implementation plan do not necessarily reflect new dollars. The Task Force would prefer that its recommendations be implemented after carefully examining the existing resources within both systems.

After consideration of its seven recommendations, the Task Force places its highest priority on establishing 30-50 secure psychiatric inpatient beds for the mentally ill juvenile offenders.

1. **Mental Health Services in County Courts**

The Task Force proposes that mental health resources be available to the court system for diagnosis, evaluation and consultation regarding children and youth.

a. Actions to Be Taken

i. Survey court system to determine present resources, perceived need and willingness of courts to accept such resources.

ii. Determine available resources in community mental health system.

iii. Develop list of needs which cannot be met from available resources.

iv. Plan for provision of resources in time phased fashion.

b. Timetable and Responsibility

i. Court survey to be developed by Offices of Mental Health, Children and Youth and Juvenile Court Judges Commission and administered in

conjunction with Conference of Trial Judges during period of January 1, 1979 – June 30, 1979.

ii. Available resources to be determined by Office of Mental Health in same time period.

iii. In rebudgeting 1979-80 appropriation for community MH/MR services (Spring 1979) considerations should be given to directing a portion of available resources to meet the need.

iv. 1980-81 Budget development should reflect documented need.

c. Cost Estimates

Each judicial district should have available as a minimum a case manager. Annual cost per judicial district approximately $18,000. Appropriate psychiatric, psychological and other professional services must be available on the basis of county population.

An estimate of annual cost is $10,000 per 100,000 people or $1,200,000, a portion of which can be met by existing resources. The 1979-80 allocation process should reflect the priority placed on this need by the Secretary and the Department.

2. **Ambulatory Mental Health Services in State Operated and State Supervised Facilities**

a. Actions To be Taken

i. Update Graff study.

ii. Determine additional resources needed by State supervised system.

iii. Determine extent of Federal participation through Titles XIX and XX of the Social Security Act.

iv. Determine ability of current Youth Development Center and MH/MR appropriations to meet the costs.

b. Timetable and Responsibility

i. Update of study by the Office of Mental Health and liaison staff by April 30, 1979.

ii. Resource needs in State supervised system by survey and field visit – Office of Social Services with OMH liaison by June 30, 1979.

iii. Availability of Federal funds – DPW Fiscal Office after steps i and ii.

iv. Availability of State resources before June 30, 1979 – OMH and Office of Social Services.

v. Budget increase if needed to occur in 1979-80 rebudget process and in preparation of 1980-81 budget request – summer 1979.

c. Cost Estimate

Estimate is $50,000 per YDC. Estimate for State supervised facilities proportionately less based on population.

State fund budget impact will be dependent upon availability of Medical Assistance and Title XX.

3. **Establish 180-210 Maximum Security Beds in Youth Development Centers for Hard Core Violent Juvenile Offenders**

a. Actions To Be Taken

i. Design appropriate admission criteria.

ii. Survey existing YDC physical plants to determine where space exists and what renovations are needed to establish units in each Region.

iii. Projects costs of renovation.

iv. Project additional staff needs in YDC's.

v. Determine existing relevant research and prepare a proposal for additional research.

b. Responsibilities and Timetable

i. Office of Social Services with Juvenile Court Judges Commission and others will develop appropriate admission criteria for the new units. This step to be completed first by March 30, 1979.

ii. Survey of physical plants to be conducted by DPW institutional architects and engineers shall be based on admission criteria and other standards developed by Office of Social Services with appropriate OMH input. Standard development to occur by March 30, 1979. Survey to be completed by June 30, 1979.

iii. Office of Social Services to determine which facilities can best serve this purpose and provide coverage to each Region.

iv. Cost estimate of renovations to be developed by DPW architects/ engineers with professional advice from Office of Social Services by September 30, 1979.

v. With approval of DPW Secretary and Governor renovation plans to be submitted to Department of General Services for development of capital budget by December 31, 1979. The 1980-81 budget cycle would then include capital item for this purpose. Actual renovation is subject to legislative authorization of funding.

vi. Office of Social Services and DPW Personnel Office project additional staffing needs to be presented in appropriate fiscal cycle coordinated with completion of renovations (at least two years after legislative authoriziation).

vii. OMH with Office of Social Services will convene a group of experts from Commonwealth research and educational facilities (WPIC, EPPI, other universities, judges, medical schools, and others) to explore the existing research and determine needs for further research. Funding of research projects to be sought from NIMH, LEAA and other Federal sources.

c. Cost Estimates

It is not possible now to predict the renovation costs. All the other steps outlined above can be accomplished by existing staff and volunteers from WPIC, medical schools, judges, etc., at the cost of travel.

4. **Services within the Mental Health System for Mentally Ill Juvenile Offenders Requiring Security**

a. Actions To Be Taken

i Admission criteria to be established.

ii. State mental hospitals to be surveyed for existing space to establish 30-50 secure psychiatric in-patient beds appropriately located near population centers across the State (probably one unit per Region). Should appropriate State facility not be available, consideration should be given to purchase of this service from private facilities.

iii. Renovation plan and timetable to be developed and submitted through Commonwealth capital construction process.

iv. Staff needs for the new units must be accurately projected.

v. Where non-secure adolescent bed deficiencies appear, DPW should make plans to open additional units.

vi. A review of the conclusions of this Task Force should be made by OMH to determine the best possible treatment modality.

b. Responsibility and Timetable

i. OMH, Office of Social Services and Juvenile Court Judges Commission to develop admission criteria as a first step by March 30, 1979.

ii. Survey of State mental hospitals for best location of the 30-50 security mental health beds to be conducted by DPW architects and engineers based on admission criteria and standards developed by OMH with appropriate consultation on security matters by Office of Social Services. Survey to be completed by June 30, 1979.

iii. OMH with Office of Social Services advice to develop proposal for establishing 30-50 beds (probably one unit in each Region) based on survey of existing space and program ability of the hospitals selected by July 30, 1979.

iv. Renovation costs at selected hospitals to be developed by DPW architects/ engineers by September 30, 1979.

v. With Secretary's concurrence, renovation plan to be submitted in 1980-81 capital budget process (November 1, 1979) for action by Governor and Legislature in the spring of 1980.

vi. Based on capital funding authorization and timetable, OMH to develop projected staffing needs for the new units (in one to two years).

vii. Update of existing survey of State mental hospital adolescent bed needs to be completed by OMH by April 30, 1979.

viii. Based on overall future plans for State mental hospitals, OMH with the Secretary to determine where and if additional adolescent beds are needed in State mental hospitals (1980-81 budget cycle).

ix. To determine whether additional treatment modalities are needed. OMH to convene workgroup of university, medical schools, judges, etc., by January 1, 1980.

c. Costs

As with the bed requirements in the Youth Development System, it is not possible at this time to project renovation costs to establish the 30-50 beds in the State mental hospitals. Additional staff needs will likewise be contingent upon actual site location and existing resources.

The other actions outlined above are possible with existing DPW staff.

5. **Mental Health Aftercare**

To provide mental health aftercare and case management services through MH Base Service Units for juvenile offenders who have mental health needs.

a. Actions To Be Taken

i. Direct County MH/MR Administrator to allocate sufficient funds for aftercare case management services by BSU's to juvenile offenders with mental health needs.

ii. Direct counties with insufficient resources to document their need and prepare requests for additional funding.

iii. Provide for BSU staff training needs.

b. Resources

Manpower: BSU staff

Funds: County base budget; carryover.

c. Time Frames/Cost Estimates

The actual cost will be determined based on individual county need data, to be phased in over a five-year period.

d. Evaluation

By OMH, based on review of county data and annual county plans and budgets.

6. **Establish Liaison Unit in OMH**

a. Actions Needed

i. Determine size of unit and define its precise mission.

ii. Determine whether appropriate staff exist within DPW to be reassigned to the liaison unit.

iii. If OMH complement increase is needed, seek Secretarial approval for its creation.

b. Responsibility and Time Frame

i. OMH with Office of Social Services input to clarify size and mission of the unit by February 28, 1979.

ii. OMH with Deputy Secretary for Management Services to determine if staff can be relocated to the unit by April 30, 1979.

iii. If additional positions needed, OMH to request them from Secretary by June 30, 1979.

c. Costs

If existing positions used, no overall increase. If new unit established, estimate a 3 person unit:

- psychiatrist
- planner
- secretary

Annual cost of unit — $65,000.

7. **Review of Laws**

a. Actions Needed

i. Survey Juvenile Court Judges and chief juvenile probation officers to determine present practices concerning the utilization of Act 143 and the Juvenile Act.

ii. Determine the reasons for differences in the implementation of Act 143 and the Juvenile Act.

iii. Develop recommendations for changes in law or regulations if necessary.

b. Responsibility and Time Frame

i. Juvenile Court Judges Commission with OMH input develops survey instrument by February 28, 1979 and conducts survey by April 30, 1979.

ii. Juvenile Court Judges Commission develops summary report, including recommendations for change, by June 30, 1979.

c. Costs

No direct costs.

APPENDICES

A. Governor's Exective Order

B. Selected Data

C. Study of Youth Development Centers

D. Studies of the State's Mental Hospitals' Services for Adolescents

E. Description of Shuman Center Project

F. Description of Jefferson Project

G. List of Persons Who Received Task Force Material

APPENDIX A

Commonwealth of Pennsylvania

GOVERNOR'S OFFICE

EXECUTIVE ORDER

SUBJECT		NUMBER
Task Force on the Mental Health of Juvenile Offenders		1978-15
DATE	DISTRIBUTION	BY DIRECTION OF
October 18, 1978	B	Milton J. Shapp, Governor

The special needs of the mentally ill juvenile offender cut across several levels of government and major program areas. Many of the mandates of current law, however, often work at cross purposes with the goals of appropriate therapeutic treatment.

In order that the Commonwealth may develop the best possible programs to deal with the special problems of the juvenile offender, I hereby establish the Task Force on the Mental Health of Juvenile Offenders (Task Force). The Task Force shall meet over the next months to formulate its specific recommendations in accordance with the following:

1. **Responsibilites**

   a. The Task Force shall review, in depth, the past and present history of all Commonwealth programs that provide mental health treatment for the juvenile offender.

   b. The Task Force shall develop a discrete definition of the mentally ill juvenile offender and shall project their service needs for the next five years in Pennsylvania.

   c. The Task Force shall survey innovative approaches employed by other states to address this problem.

   d. The Task Force shall review the legislative, judicial, and executive trends which have emerged in this field in Pennsylvania.

   e. The Task Force shall review and assess existing plans and programs within the Department of Public Welfare that address this issue.

   f. The Task Force shall recommend those legislative and administrative actions necessary to address comprehensively and with consistency the mental health treatment needs of the juvenile offender.

   g. The Task Force shall pursue its responsibilities through hearings or other means as necessary. All hearings so held shall be open to the public.

2. **Composition.**

   a. The Task Force shall be comprised of eleven members appointed by the Governor and the following ex officio members: The Secretary of Public Welfare, the Attorney General, the Deputy Secretaries of Public Welfare for Mental Health and Social Programs, and a representative of the Pennsylvania State Association of County Commissioners.

   b. Members of the Task Force shall not be compensated for their services but shall be reimbursed in accordance with procedures established by the Governor's Office for expenses necessarily incurred in the discharge of their official duties.

   c. The Task Force may accept private or public funds to assist in fulfilling its responsibilities.

3. **Interdepartmental Cooperation.**

   All agencies under my jurisdiction shall cooperate fully with the Task Force and shall provide such assistance and information as are needed by the Task Force to carry out its functions in an effective manner. The Governor's Office and the various administrative departments and agencies shall supply staff and support services as necessary.

4. The Task Force shall report its findings, conclusions, and recommendations to the Governor on or before December 15, 1978, and shall thereafter cease to function.

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Appendix B

SELECTED DATA

Population Universe of Concern to Task Force

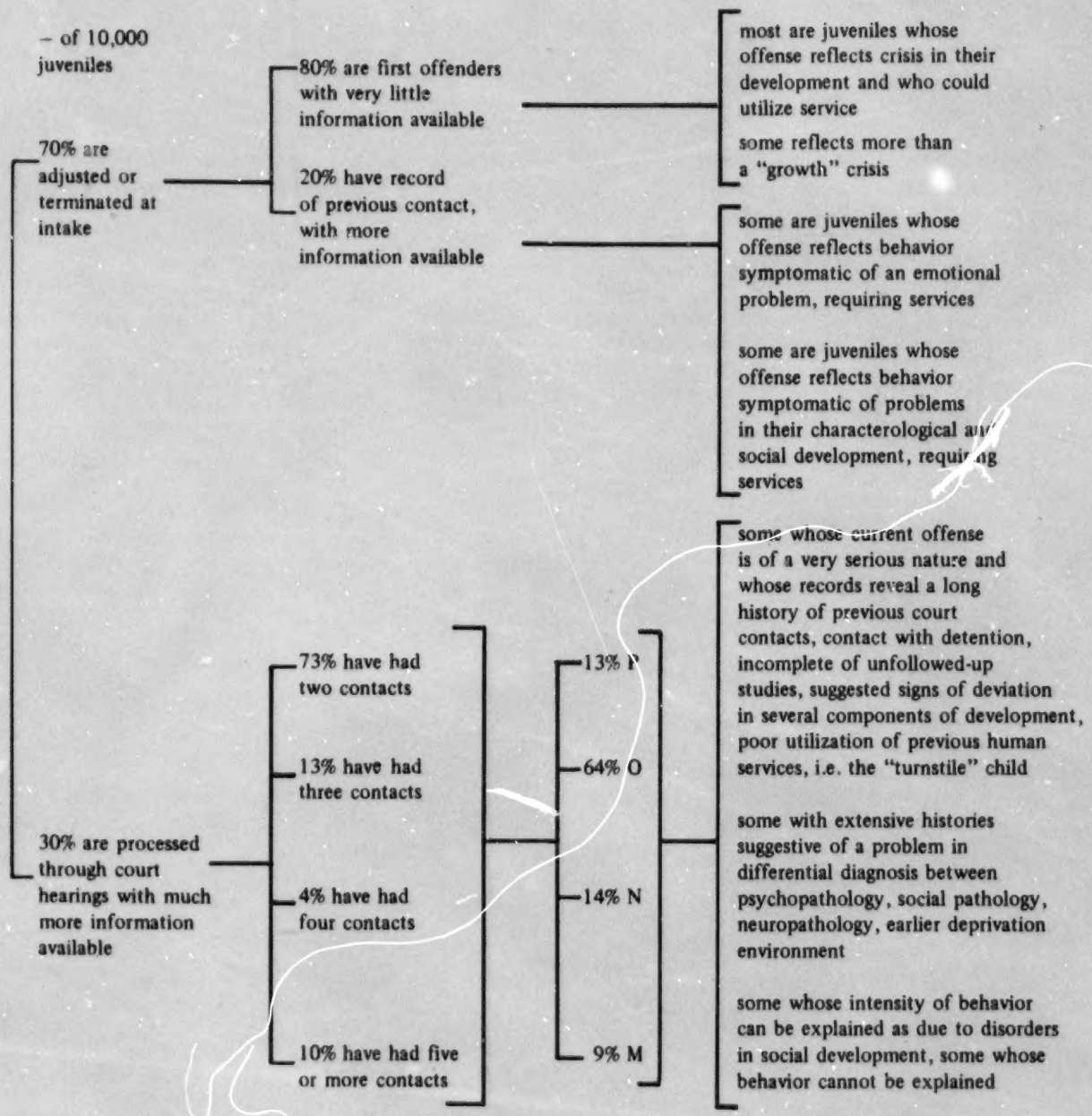
Without belaboring the rather primitive state of the data and information available by which to define accurately the juvenile population of concern to us, sufficient information is available at least to allow us to draw in grossly the parameters of this universe.

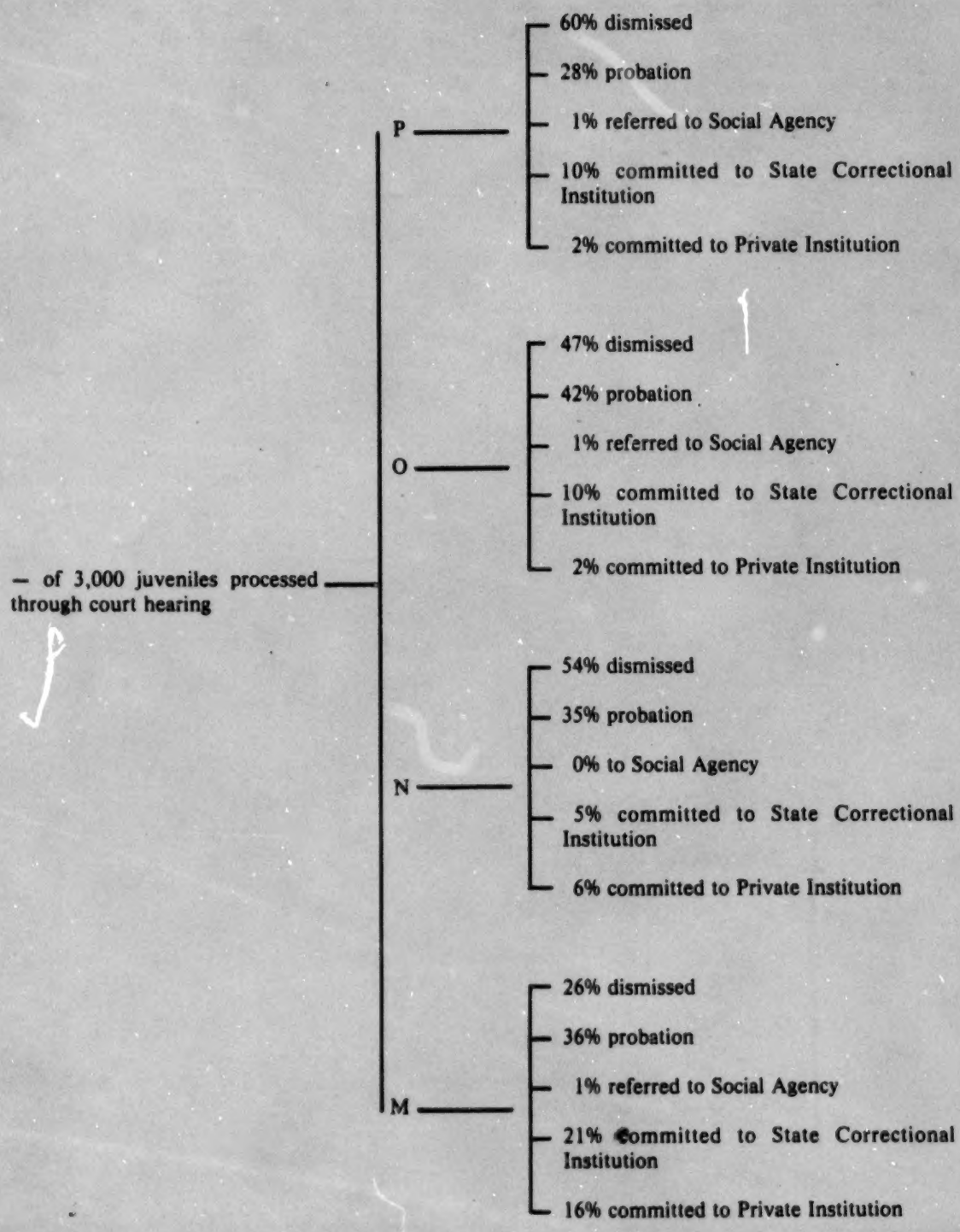
A. Microscopic View of this Population Universe

Based on local studies of one urban county (Allegheny) in Western Pennsylvania, which provide results grossly similar to other studies, the various diagrams to follow can serve as illustrations of the estimated boundaries pertinent to the narrowly or broadly defined subject of the mental health of juvenile offenders.

of 10,000 juveniles brought to attention of Juvenile Court in a year (prior to minor status offense diversion) 1975-1977

- 13% are charged with offense of **aggressive acting out against** persons (murder, voluntary manslaughter, rape, assault, robbery, arson). (P)
- 45% with offense of **aggressive acting out aginst objects** (burglary, auto theft, theft, purse snatching). (O)
- 16% with offense of **minor status nature.** (M)
- 3% with offense of traffic violations. (N)
- 23% with offense of drug and alcohol possession and sale, criminal mischief, other. (N)


– of 10,000 juveniles
70% are adjusted or terminated at intake
80% are first offenders with very little information available
20% have record of previous contact, with more information available
most are juveniles whose offense reflects crisis in their development and who could utilize service
some reflects more than a "growth" crisis
some are juveniles whose offense reflects behavior symptomatic of an emotional problem, requiring services
some are juveniles whose offense reflects behavior symptomatic of problems in their characterological and social development, requiring services
30% are processed through court hearings with much more information available
73% have had two contacts
13% have had three contacts
4% have had four contacts
10% have had five or more contacts
13% P
64% O
14% N
9% M
some whose current offense is of a very serious nature and whose records reveal a long history of previous court contacts, contact with detention, incomplete of unfollowed-up studies, suggested signs of deviation in several components of development, poor utilization of previous human services, i.e. the "turnstile" child
some with extensive histories suggestive of a problem in differential diagnosis between psychopathology, social pathology, neuropathology, earlier deprivation environment
some whose intensity of behavior can be explained as due to disorders in social development, some whose behavior cannot be explained


— of 3,000 juveniles processed through court hearing
P
60% dismissed
28% probation
1% referred to Social Agency
10% committed to State Correctional Institution
2% committed to Private Institution
O
47% dismissed
42% probation
1% referred to Social Agency
10% committed to State Correctional Institution
2% committed to Private Institution
N
54% dismissed
35% probation
0% to Social Agency
5% committed to State Correctional Institution
6% committed to Private Institution
M
26% dismissed
36% probation
1% referred to Social Agency
21% committed to State Correctional Institution
16% committed to Private Institution

Before proceeding, attention is called to the fact that the above diagrams are based on data collected during the period of 1975-77, and includes the population of juveniles now diverted as status offenders. Despite this the diagrams, and other data pertinent to the mental health needs of this juvenile population, suggest that our population universe is a heterogenous group running the gamut of need for mental health services, including: crisis intervention (for immediate intervention in the crisis in development); diagnostic work-up; psychiatric inpatient treatment; ambulatory, long-term treatment; consultation to other services; supportive services to non-mental health staff.

B. Microscopic View of This Population Universe

Based on a structured visit to institutional and community-based human services in Western Pennsylvania offered to juveniles referred by the Allegheny County Juvenile Court (i.e. Youth Development Center, George Junior Republic, Abroxos, Group Homes, etc.), and based on a review of the records of 500 juveniles who at the time of the study (1975-77) had been or were in residence at these programs, the diagrams following can also serve as illustrations of the parameters of our population universe of concern.

– of 500 juveniles in placement at an institutional or community based program

- 80% are male, 20% female
- 57% are white, 43% are black
- 38% had been residents in a public (non-psychiatric) institution at some time prior to this placement
- 5% have a previous psychiatric hospitalization history
- 62% are from non-intact families
- 23% have a recorded psychological test result of above 100 I.Q., 50% with an I.Q. between 80 and 100, 27% with an I.Q. below 80
- 70% come from families with five or more siblings
- prior to this placement, 38% had lived with both parents, 38% had lived with one parent, 12% had lived with relatives, the remainder had lived in a public institution or foster home
- 85% with family history suggestive of social pathology
- 15% had recorded histories of a chronic health problem, i.e. epilepsy, diabetes, orthopedic problems, hearing loss
- 50% identified as having learning difficulties
- 68% had a recorded history of sibling dysfunction, i.e. court records, school dropouts, mental illness, mental retardation
- 70% had recorded information of three or more past contacts with human service agencies

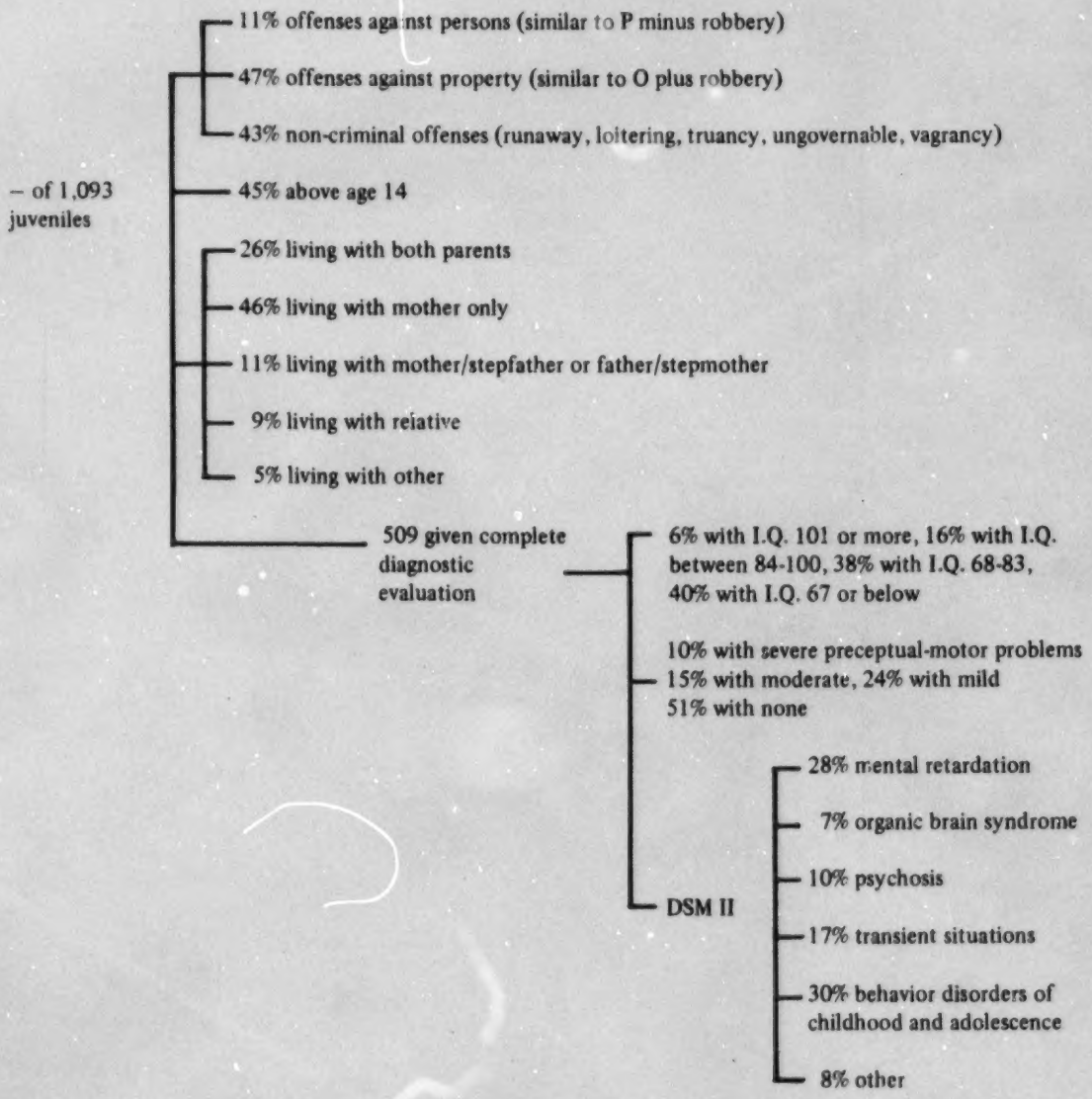
C. Another Microscopic View of the Juvenile Population Universe of Concern to the Task Force

Based on the comprehensive neuropsychiatric assessment of 25 juveniles, referred by the Allegheny County Juvenile Court, who were in residence at the Shuman Center Detention Program, the below profile of the following emerges.

- of 25 juveniles (current)
  - Offense charge
    - 60% P
    - 40% Other
  - 84% male, 16% female
  - 24% under age 14, 52% 15-16, 24% 17+
  - 56% black, 44% white
  - 16% with I.Q. above 100, 56% with I.Q. 82-100, 28% 81 or below 10
  - 52% normal EEG, 48% abnormal EEG
  - 84% previous contact with court
  - 92% non-intact family
  - prior to contact 4% lived with both parents, 20% with one parent, 12% with relative, 8% foster parents, 56% lived in institutions
  - 48% previous psychiatric hospitalization history
  - 60% demonstrated learning difficulty
  - developmental history, 20% prenatal and birth problems, 36% child abuse or neglect, 56% parental divorce, 24% parental death
  - 15 juveniles with aggressive and violent – DSM II
    - Schizophrenia 1
    - Inadequate Personality 1
    - Unsocial aggresive reaction 10
    - Group delinquency 1
    - Personality disorder 1
    - Social maladjustment 1

D. Microscopic View of a Similar Juvenile Population Elsewhere

Based on reported studies of a population of juveniles held in detention in 1972 - 1973 in New Orleans, the following picture emerges.


– of 1,093 juveniles
11% offenses against persons (similar to P minus robbery)
47% offenses against property (similar to O plus robbery)
43% non-criminal offenses (runaway, loitering, truancy, ungovernable, vagrancy)
45% above age 14
26% living with both parents
46% living with mother only
11% living with mother/stepfather or father/stepmother
9% living with relative
5% living with other
509 given complete diagnostic evaluation
6% with I.Q. 101 or more, 16% with I.Q. between 84-100, 38% with I.Q. 68-83, 40% with I.Q. 67 or below
10% with severe preceptual-motor problems
15% with moderate, 24% with mild
51% with none
DSM II
28% mental retardation
7% organic brain syndrome
10% psychosis
17% transient situations
30% behavior disorders of childhood and adolescence
8% other

Appendix C

MENTAL HEALTH PROBLEMS WITHIN THE YOUTH DEVELOPMENT CENTERS COMMONWEALTH OF PENNSYLVANIA

Purpose

The purpose of this report is to describe the current status of mental health problems and the ways they are handled within the Commonwealth's System of Youth Development Centers. The desire for such a survey came from several sources. The writer was approached by Dr. H. Allen Handford, Director of Children and Youth Services, Office of Mental Health in March, 1977 about the concerns of the Department of Public Welfare for such a study. It was his desire to learn how much or to what degree the mental health needs of these youth were being adequately served.

The belief that such a survey was required originated within the Office of Social Services under Deputy Secretary Gerald Radke. It was recognized by everyone concerned that a study of the entire Youth Development System would be more productive of problem identification and solution than a specific focus on a single institution. It was for this purpose that the writer was commissoned by joint agreement of Dr. Robert M. Daly, Deputy Secretary/Commissioner of Mental Health and Mr. Gerald Radke to undertake the project presented here.

History

The relationship between juvenile delinquency and emotional disorders is a long and confusing one. The issues are at once emotional, scientific, and academic, but it is evident that they have not yet been settled. One cannot objectively state with clear evidence that juvenile delinquency is a social problem or an emotional disorder. In talking with counselors in the YDC system who work on a daily basis with youth, I found sharp disagreements. One program director who grew up in a black ghetto argued that while some of his neighborhood contemporaries became delinquent, he did not; thus he saw it as an individual emotional problem. Others who work best with what they call the "socialized" delinquent conceive of the problem as one of social background, within the family, the peer groups, and the local subcultural milieu.

There are several historical imperatives that precede such views. Although the readers of this report are familiar with them, I believe it would be helpful to mention them since they have a strong effect on the views expressed in this report. The question they raise is: Is, or should, the YDC system be primarily correctional, rehabilitational or therapeutic? My preliminary view is that the system is primarily rehabilitational. What then, should be the place of correction or therapy?

It is my impression that the earliest forms of legal intervention into juvenile delinquency were primarily correctional. The concept that delinquency was one form of criminal behavior resulted in the building of reform schools, i.e., prisons for adolescents. This was consistent with the idea that "acting out" was due to "badness," either socially or constitutionally (in the biologic sense) mediated. The prevailing situation in mental health areas would have forced agreement. Psychiatry at that time also held an institutional position. Few adolescents came into contact with the system unless they were floridly and undeniably psychotic, so that there was no mistake about which system should be responsible for handling them.

With the publication by August Aichhorn in 1935 of "Wayward Youth," a new theory of delinquency was announced. Aichhorn, a psychoanalyst, reported that untoward behaviors were symptoms of severe neuroses that could be treated by intensive psychotherapy or psychoanalysis. His was an extreme position, but was consistent with the euphoric view (lasting almost 30 years) that psychoanalysis provided the foundations to cure any emotional problem or unacceptable behavior.

Both the correctional view and the therapeutic view can be understood now as extremes which cannot be applied across the board. Both, however, retain a necessary place in the system, as exemplified by the need for security units and for therapeutic modalities in tandem.

It is well known to the social service sector, but probably less known to the mental health sector, that the services available to the adjucated juvenile have changed significantly over the past 10 years. These changes are symbolized by the closing of Camp Hill, the creation of open facilities within the Youth Development Centers (even the name change is an

important one), and the conversion of residential centers to community based facilities. Emphasis is now on diagnosis of the individual problem, an approach to individualized planning, and utilization, in so far as possible or tolerable, within the home community. Such rehabilitative programs are difficult to institute because of community opposition, but have the advantage of using available community resources, physical and psychological. The current programs have been started without falling into the already familiar trap of polarization, i.e., immediate shutting down of all non-community facilities. A rehabilitative individualized approach has the advantage of being flexible, that is employing either or both correctional and therapeutic techniques when indicated. Central and a priori, however, is the question: Is Juvenile Delinquency an emotional disorder, or, rather, are there some juvenile delinquents who have, as part of their problem, an emotional disorder? The answers to these questions will help in planning appropriate mental health services to the Youth Development System.

Method

Following authorization by the Deputy Secretaries for Mental Health and for Social Services, we planned to visit the YDC System throughout the Commonwealth. Each visit was preceded by contact first with the Regional Commissioner for Social Services and then by the director of the institution. On each visit I was accompanied by a staff member of the Central Office for Youth Development Service, either William Shaffer or Horace Lowell. Our plan of operation was to talk with the director or his designee, to discuss our interests with program directors and anyone else who was available, to peruse records, to talk with line staff, to interview youth whom we might run into, and to inspect the physical facilities. For the most part we were able to accomplish all of our objectives with the open and friendly cooperation of those whom we met. We then planned the present preliminary report of our initial findings. It should not be construed as a final, indepth study. Much more observation will be required to discern the total patterns of mental health needs and the ways to supply them. We hope to continue this effort at the conclusion of the report.

Seven of the nine facilities were visited. Those in the Philadelphia area were visited more than once. We decided to prepare the report before visiting Youth Forestry Camps No.2 and Youth Forestry Camp No. 3 because:

1. We wished to submit the reports as early as possible.

2. We believed that the major mental health concerns will be located in facilities other than Youth Forestry Camps.

3. We believe that Youth Forestry Camp No. 1 represents the quality of mental health input of the other two.

4. We consider that any implementation of recommendations in this report will benefit the sites not yet visited.

5. We plan to visit the Youth Forestry Camps as soon as this report is completed.

General Impressions

There is evidence that concern about the mental health issue among adjudicated youth is not a new one. As long as ten years ago, it was reported to me, an official of the Office of Social Services (Dr. Don G. Lederman) was interested in the problem. In a recent report on a survey conducted by him of the DPW's Central Region, he continued to voice his feeling that mental health services for the emotionally disturbed, acting out adolescent are, at least for his region, felt to be inadequate.

In a study which is much more pertinent to the problem discussed in this report, Edward Uder and Richard Lewis found, by way of a pilot project, that the numbers of juveniles who have psychotic and psychotic acting-out profiles have increased at New Castle YDC. They also state that this statistical impression is backed up by their clinical experience.

The impressions reported above have been corroborated by some, but not all, of the people interviewed at the various YD facilities. This seems to depend on the type of facility, its goals and organization, and the specific training and expertise of the staff.

Preliminary Diagnostic Categories

The categories of diagnosis presented in this section are idiosyncratic and do not follow the official

diagnoses of either Diagnostic and Statistical Manual II (DSM II) or the proposed DSM III. I have chosen these in order to simplify my discussion and to make it easier to consider operationalization of any suggestions. These are also the general ways in which the YDC system heuristically views their students: (1) the psychopath, (2) the socialized juvenile delinquent, (3) the emotionally ill, (4) the status offender, (5) the retarded. Note that I do not present the term "acting out" as a diagnosis. This is because "acting out" is basically a catchword derived from the psychoanalytic literature, but now transformed into a catch phrase meaning behavior which is not approved by the community which judges the behavior. It can include anything: violence, rape, arson, theft, psychotic behavior, temper tantrums, truancy, running away, inability to get along with others, and the like. It is my contention that "acting out" is a symptom which has many causes and may be subsumed under any of my five diagnostic groups.

The Psychopath

The term derives from the old psychiatric diagnostic category of "constitutional psychopathic inferior." What it meant was an inborn, congenital amorality that was unresponsive to any intervention. While we may argue against the theory that it is inborn, the case still remains that these people are difficult to change. They seem to have no conscience, no concern for anyone else and no remorse. They can feel anxiety and depression, but only if they are put in an untenable position. Others in the environment are there to be exploited. They view therapeutic intervention as simply another manipulation, either for them or for others. Workers inside and outside of the YDC system are pretty much agreed that they are next to impossible to treat, and so they do not fit into a youth development program or a psychiatric therapy program. Those line workers and supervisors to whom I spoke did not want them in the system because of their disruptiveness. This even included the security units. They felt that they were **best handled as adults in prison.** While I do not think the case is closed, I believe that for now this position has merit and should be considered. I also believe that much more study for improved treatment methods needs to be undertaken.

The Socialized Juvenile Delinquent

In contrast to the psychopath, the socialized juvenile delinquent has matured or developed enough to be able to relate to others to form bonds with other people, whether adults or peers, and to have some concerns about their feelings and reactions. His delinquent behavior can sometimes be traced to disordered family life, the environment, the subcultural mores, or the facts of life for him concerning his own survival. Because of an ability to relate to others, he is capable of working with the staff of a YDC and to profit emotionally and maturationally.

This is the group that the staff feels competent to work with and enjoys doing it. It is probably also the group with which they have some success.

The Emotionally Ill

This group is the one that prompted the present work. They can be either delinquents who also have an emotional disorder, or can be diagnosed as delinquent because that is the outstanding symptom of their emotional disorder. Within this category can be included anything from neuroses to personality disorders to psychoses. The YDC staff feels incompetent to treat this type of person because they feel out of their depth and away from their area of expertise. They look to the mental health sector, either the MH/MR or the state psychiatric hospital, for help and often believe they are rebuffed. This will be discussed in a later section. They find that such a person does not fit into their own therapeutic program at best. At worst they take up too much staff time which the line staff feels is more profitably spent on treating the non-ill youth, those whom they see as fitting into their charge and for whose care they were trained.

The Status Offender

Many whom I talked to took the position that the status offender, those whose offense is based on their position as a juvenile, do not belong in the YDC System. I do not wish to debate this. It is evident to me, however, that many of these youths do have emotional problems, usually neuroses or personality disorders, that require treatment. The YDC System may not be the ideal place to treat them, but in some cases it provides the sole source of therapy. This area must be studied in depth to formulate more efficacious ways to treat them.

The Retarded

For the most part retardation is organically or genetically based. It may he hereditary, due to disease, or trauma. In the majority of situations, it does not respond to therapy. Whether or not the YDC System

provides the best method for this population requires further study.

Special Cases

I refer here to the rapist, the arsonist, and other special types of juvenile problems. I was told that the rapist may enter the YDC System, and act as a model youth, giving no trouble to anyone, yet when he leaves he may rape again. The implication is that the therapy provided by the system does not touch such a person. Other techniques have been used outside the system with some success. These should be looked into. Since the system probably will get rapists because people want them out of the community, the therapeutic modalities could be brought into the system.

The arsonist is another example within this special category. Arson in most juveniles is a symptom of emotional disorder and may be handled as such. The problem is that the staff fears the arsonist and doesn't want him around.

Other special problems can be taken up as the need arises.

Therapy in the System: General Impression

During my visits I was able to talk with directors, division leaders, supervisors and line staff. The majority of them were openly spontaneous in presenting their ideas of the good and bad things within the system. They felt competent to treat those juvenile delinquents who were of the socialized group. They had much experience in doing so and were comfortable in their role. I was impressed with their general capabilities. The system is organized along the lines that has made it possible for those with clincial experience to advance to supervisory and then to management roles. It is a particular strength of the system because it provides a managerial cadre who know through their own participation the problems of the youth and the vicissitudes of coping with them and their problems. I asked one director who in his organization handled the most difficult therapeutic problems. He replied that he did, since he had the most experience and was able to organize his time to do so. In only one specific instance I felt that therapeutic efforts did not match those that are usually employed in the treatment of youth. I will discuss it specifically under the section on individual units.

With the one exception, therapeutic efforts are systematized along criteria employed in private, nonprofit mental hospitals with specialized adolescent treatment centers. Both private adolescent treatment centers and the Youth Development Centers have in common an adequate staff-youth ratio, therapeutic expertise, a treatment plan, intensive treatment on a full day basis (including education), attention to participation in the social milieu both on-campus and off-campus, and individual and group therapeutic contacts. What are sometimes not provided in individual Youth Development Centers are (1) psychiatric input into each treatment plan, (2) strict adherence to the treatment plan.

As stated before, and emphasized here, the treatment staff of the YDC's are well trained to treat the socialized juvenile delinquent and are comfortable in doing so. They are not trained to diagnose and treat the mentally ill delinquent or the emotionally distrubed youngester who gets into the system, nor can they be expected to. Their training is not in that area, so that they are understandably unable to make an appropriate diagnosis, develop a proper treatment plan, institute psychotherapy, prescribe drugs correctly, accurately monitor drug effects, and judge the results of their treatment. This in no way detracts from their therapeutic ability, but they do not have the cognitive set to administer that form of treatment. It is in this area that mental health participation is required.

Individual institutions have varied in their pleas for mental health input. This has depended on the numbers of emotionally ill juveniles who have been sent to them, the adequacy of psychiatric and psychological consultation available to them as part of their own staff complement, and the comfort of the staff in approaching emotional disturbances. One strong impression that I received on my visits is that each separate center has its own way of looking at emotional problems and their ability to cope with them. It is this individuality within the system that necessitates separate commentary on each center and permits me the observation that each one is only as good in dealing with mental health problems as the attitudes and views of the local staff. Thus, each center requires separate planning as well as system-wide mental health input.

Numbers of Youth in the System with Emotional Disorder

Under current diagnostic programs, the accurate numbers of emotionally disturbed youth in individual centers is difficult to ascertain. Some centers reported high numbers of emotional disorder, while others reported practically none. In some centers

psychometric examination is an integral part of diagnostic workup and treatment planning, while in others, psychological and psychiatric input is obtained only when a problem manifests itself. Thus, covert problems may not be uncovered, or if a youth does show an overt problem, staff may have ways for immediate intervention. One of my recommendations is to study the actual numbers of emotionally distrubed youth in the system. This will be discussed under the Recommendations Section. What is available now is a listing of those youths who have had previous psychiatric hospitalization or treatment, which does provide a partial statistic on the problem.

Adequacy of Mental Health Input: General Impressions

The adequacy of mental health input into the YDC System is a highly individual matter for each institution. It may vary from full time psychiatric staff in the case of Cornwells Heights to partial input at New Castle, even less at Waynesburg to none at Loysville for example. While number of hours and days may be high, such input may not guarantee that enough is available to handle the needs of the institution, because of high needs. It also depends on the possibility of providing in-service training for staff in psychiatric problems. It appears that considerably more in-service training is desirable both for staff education and in many cases to change staff attitudes about mental illness.

Community availability of needed psychiatric support is often lacking. This problem occurs in two distinct areas: (1) the local MH/MR resource, and (2) the state hospital adolescent center. Directors complained that they had difficulty in getting youth into local mental health facilities because of reluctance on the part of the facility to provide services. They saw this as due to two reasons: (1) the view of the MH/MR Center that the YDC was not a part of the local community and that the problem should be dealt with by the MH/MR Center in the juvenile's own home area; (2) the general reluctance of the MH/MR Center to deal with a violent or acting-out youngster. These attitudes often led to an inability of the YDC to obtain help in a crisis or to get adequate acute treatment.

Directors who have had to send youngsters to State Mental Hospital adolescent units also voiced complaints to me. They felt that the units were reluctant to treat adjudicated delinquents and often sent them back to the YDC before their emotional problem was solved. They saw this as yet another failure to receive cooperation from the Mental Health System. On the other hand, directors of State adolescent centers with whom I spoke stated that their units did not have the staff or the time to handle violent, acting-out youngsters. They also expressed their concern over the potential harmfulness of such youngsters to other patients. What occurs is that no one feels adequate or secure in coping with such juveniles, so that they are shuffled back and forth from system to system without adequate care. I believe that cooperation between the two systems in treating these problems should be organized on a formal basis between directors with a priori planning.

Physical Plants: General Impressions

In all cases I was allowed to inspect the offices, dormitories, schools, and recreational facilities of the centers. I came to the conclusion that the centers provide the necessary physical facilities for the care of the youth.

In all cases the plants were well cared for and neat. This surprised me because I am aware of the tendency of adolescents to express rebellion by messiness and by not caring for their surroundings. This is particularly true in private facilities, where walls are defaced (often by permission of staff) and furniture torn up. That this does not happen in the YDC's attests to the ability of the staff to adequately control one form of acting out behavior.

In the case of some centers, most notably Waynesburg, the facilities are very attractive, reminding one of small college campuses. Loysville also, while old, reminds one of an old country college. I stress this as important because I see this in terms of the YDC's providing excellent physical milieus, which I believe promotes mental health.

Cornwells Heights

During my visit to Cornwells Heights I was accompanied by William Shaffer. I was able to speak with the Director, Mr. Charles Nallin, program directors, line staff, and juveniles. I also spent time with the psychiatrist, Dr. Melvin Marcus, and with other doctors on the staff. The facility is well kept and clean. There are several areas of authority — the therapeutic staff, the security unit run under contract by RCA, and the support staff — which may complicate integrated planning for the individual. Treatment plans are well organized and are checked for compliance. Meetings are held monthly, giving little

time for comprehensive team inputs for the individual.

The part time psychiatrist states that, in his view, 60% of the youth at the facility are mentally ill. A more tempered view by the director is that the problem has not really been defined within the facility. He thinks the rate may be higher than 50% but at least 25% of the problems have been identified. He considers the lack of accuracy is due to less than adequate input and communication between the various staffs, referring to the dichotomous views that obtain between social work groups and psychiatric groups, despite inservice training. For example, while psychiatrists require specific diagnoses to justify treatment, social work often is concerned that this provides a stigmatic label that will haunt the person all the rest of his life.

This YDC is distinguished positively by the presence of a full time psychiatrist with training in problems of adolescence. Yet only 8 juveniles at that time were on medications, all monitored and all prescribed. In some cases the youth was already on phenothiazines when he entered. On the other hand, use of illicit drugs is sporadic and confined mostly to marijuana. Other problems, like violence and homosexuality, are also sporadic and handled by group pressure and loss of privileges.

The psychiatrist has considered organization of a special therapeutic unit for emotionally disturbed delinquents but believes that it would be transformed into a security unit. He has instituted the policy, which I support, of limiting his drug orders to seven days, with automatic discontinuation unless re-prescribed. He sees the main therapeutic effort as supportive and directive by the line staff with only sporadic use of individual and group therapy. He finds himself hard pressed to find the time for definitive individual therapy. He can see a few patients two to three times a week. He concludes by requesting a treatment center located at the facility where he can direct more concentrated therapeutic efforts. His desires express his need to have more therapeutic authority, but this may also have disadvantages understood by those more knowledgeable about the workings of the system.

Philadelphia YDC

I visited the facility with Horace Lowell. It is located in old hospital buildings in North Philadelphia. At first glance it is in need of repair but it serves its purpose well. At this time it is a day and community program with little in-patient usage. Thus they are not in a position to deal with emotionally disturbed youth on an intensive basis. At the same time they do not see much emotional disorder because (1) they do not identify it, (2) the emotionally ill delinquent is channeled off into other facilities. For this reason they have no accurate statistics on the amount or degree of mental illness in their population. They do have to deal with crises, however, and seek the services of the community mental health programs. They feel that, while it is available, it is not responsive as rapidly as they require. I have given some thought to it and have considered a plan that would give them daily coverage by a psychiatrist supplied by a local medical school on a contractual basis. This can be done at minimal cost if that person is a senior resident.

The nature of their program helps to avoid having to prescribe medication or utilize seclusion, so that they do not see it as a current problem. This type of facility is capable of using community programs and so their mental health problems are not like those of the residential units.

Youth Forestry Camp No. 1

In contrast to Philadelphia YDC, this is a residential facility with a population in the 50-60 range. In that group there may be three to six "problem" juveniles, about a 10% average. By this they mean residents who are disruptive to the community. Their small size moves against having full time psychiatric coverage, but they are able to "tie-in" with the local MH/MR Center for diagnoses, treatment, and in-service training. Unfortunately, they have to go to the Center since it is unable to come to them. Perhaps this can be corrected by working out a liaison program.

A nurse is on the premises who dispenses and monitors medications. There is no quiet room and no physical restraints are employed. The director's philosophy is that if a locked room were available it might be overused. He would especially deplore it for mentally ill adolescents. The director is very active in working with his disturbed charges and seems very capable of doing so. He knows how to set up therapeutic situations to handle violent and destructive behavior and has been successful at it. My impression is that the staff here is quite responsive to the needs of the juvenile as instinctive therapists. On the other hand, they do not handle the most severe mentally ill adolescents because these youths cannot handle their type of rehabilitation program and do not remain on the premises.

In conclusion, the facility has needs for some mental

health support but not on a full time basis, since they can treat less severe problems and can refer the severe problems to other YDC's.

Waynesburg YDC

It is Waynesburg YDC that most helps to strengthen the concepts that:

(1) Each facility develops its own independent view of how emotional disorder is to be approached.

(2) The facility's approach depends on the philosophy of the local staff.

(3) The approach leads to use of local distinctive therapeutic modalities.

Waynesburg YDC is distinctive from all the other YDC's in three main areas:

(1) It is physically the most attractive facility. It looks like a more modern small college with attractive girls' dormitories.

(2) Its philosophy is more openly controlling and infantilizing of their adolescents, in contradistinction to the other YDC's. This may have to do with fact that the preponderance of staff and youth are female.

(3) Its use of medication and of seclusion is above that of the other YDC's, expressing both a concept that they are needed and that they are successful in handling problems.

The census at the time of my visit was reported as 131 in residence and 17 in community based programs. There were no specific records of the number of emotionally disturbed residents. A psychiatrist comes to the facility one afternoon a week and one Saturday a month. There were 38 adolescents on drugs at that time of which 27 are on tranquilizing medication (20%). These include mostly Stelazine and Mellaril. There is no available time for psychotherapy despite the psychiatrist's recommendations that it be employed in some instances.

The other distincitive element of Waynesburg was the use of the "sleeper" system. This is a euphemism for seclusion or isolation. At the time of our visit there were five "sleepers." A "sleeper" may be sent to seclusion by staff or may request it. The seclusion room is bare and locked; once someone enters it there is not other way for him or her to respond except to sleep. I was unable to determine the therapeutic rationale for its use, the criteria for its termination, or understanding of its effect.

It is too early at this writing to make recommendations since we have not yet been able to determine how the YDC arrives at its concepts. I would suggest that we look further into the mental health program at the facility with the intent to lend it further psychiatric input and program development. Perhaps a full time psychiatrist can be found, or a team organized for full time coverage.

New Castle YDC

New Castle YDC is both programmatically and physically the Western counterpart of the Cornwells Heights YDC. The staff, knowing that I was coming (escorted), had prepared to meet me and to discuss with me the problem of emotional disorder at their unit. Their presentations were consistent in that (1) there was a severe problem of emotional disturbances at New Castle, (2) they were very concerned about it, (3) they wanted all the help they could get. All in all, their plea seemed sincere and genuine, and quite impressive. Their part-time psychiatrist was able to rearrange his schedule to meet with me. Dr. Matta is a highly trained adolescent psychiatrist who would grace any program. He has time to work up individual cases and do therapeutic follow-ups, but desires more assistance from other psychiatrists if they were available.

The facility has two full time psychologists who have documented the growth of emotional problems at the facility. They see the problem as growing over the past four to five years until there were at this time 46 adolescents on medications for problems ranging from neurosis to psychosis. All medications are prescribed by Dr. Matta who is able to closely monitor their effects. The line staff is grateful for Dr. Matta's presence but is concerned about the disruption of programs by a disturbed youth; "one kid can take 80% of the staff time."

Dr. Matta is concerned by the lack of back-up psychiatric facilities for disturbed patients. The local

MH/MR Center does not accept his referrals so he utilizes programs in Pittsburgh. Unfortunately it is both difficult to get an appointment and then to transport the patient there.

The staff here strongly stated that their job is to handle juvenile delinquents, not emotionally ill kids. They are worried that even the physical plant is not properly constructed for it. There is much more to add about the concerns of the staff about the problems they face. I think that many of them are real and that they deserve careful consideration and support with beefing up of what is already a good preliminary program. It could be that having a taste of psychiatric input, they are now more aware of it and so want more. This can be viewed as positive.

Warrendale YDC

This is a diagnostic center that, like Philadelphia, does not have to deal with emotional disorders. They have the ability to re-refer to another area for treatment. They can use Western Psychiatric Institute for their work-up. Little more needs to be said about their problems since they are few.

Interestingly, when Warrendale was an inpatient unit, medications were never used because of the philosophy that medications only masked problems. The staff also knew that it was not feasible to use medications because of lack of personnel to monitor their effect.

The staff psychologist finds that 30-50% of the youth sent for diagnosis have emotional disorders severe enough to justify professional intervention, and they find it feasible to utilize professionals in the day treatment centers or the MH/MR Center in the treatment center catchment area. Apparently this works for the facility.

The most valuable part of my visit there was to discover their Intake and Diagnostic Guide (I.D.A.). It is complete and thought out enough to be adopted by the whole YDC System. We should discuss this in the future.

Loysville YDC

Loysville YDC is located in a rural area. The facility is old, once having been a church-related orphanage school. It has a charm which seems to be appreciated by its residents, since there were no signs of defacement or vandalism sometimes seen in areas where adolescents live.

During my visit I was able to speak at length with the assistant director and the two staff psychologists. It was their feeling that they do not get as many emotionally disturbed youth as before, but are seeing more "flat out delinquents," i.e. psychopaths. They describe the emotional problems they encounter as mostly schizoid kids who withdraw or elope. They understand the potential of adolescents remanded to a YDC to withdraw.

The psychologists provide comprehensive testing to each admission. They do find about 10% Minimum Brain Dysfunction. In the past about 35%-40% of those tested showed some emotional disorder, but it was mostly located in the diagnostic unit rather than the residential unit, and the percentage has dropped.

Therapy is provided by the line counselors, although the psychologists may handle the more difficult cases. They are able to provide one to two days a week individual therapy. The numbers of florid psychotic adolescents has been minimal, perhaps one or two. A psychiatrist used to consult once a week but they have recently been without one. They have just secured the services of Dr. Charles Cladel for staff training, medication supervision, and psychotherapy supervision. At this time few residents are on drugs; those who are, are supervised by the medical doctor who is on the premises two hours a day. He tries to stay away from prescribing psychotropic medication. There is no isolation unit since "it is now allowed by the Central Office" but the staff was agreed that one is not needed. It is evident again that the on-site staff determines the program.

The staff utilizes a treatment plan. An attempt is made to interview every family. My impression was that the psychologists were comfortable in working with the residents and confident in their system. One made the statement that when the psychiatrist joins them he will "have to be trained" to understand the special problems of delinquency and related emotional disorder.

The assistant director is concerned about bizarreness and "acting out" which the environment may trigger. He favors a separate facility for such "dual diagnosis" adolescents in order to provide greater and more intensive staff attention, a theme often expressed by the YDC line staff. One unique therapeutic modality used at Loysville is "aggression exercises" through role playing to drain off the aggressive energy.

The staff here seems flexible and innovative. To me this means a greater possiblity of solving individual problems as they arise with a minimum of damage to the program.

One last observation is that they find the local MH/MR Center resistant to helping them with acute problems. They can, however, use Dauphin County MH/MR Center.

Summary of Findings

1. The problem of the emotionally disturbed juvenile delinquent is a real one, and may be increasing in frequency.

2. The numbers of actually emotionally disturbed adolescents in each YDC is unknown, and there are no valid statistics for the entire system.

3. The numbers of recognized emotionally disturbed residents in each individual YDC is cyclic.

4. The argument over whether all juvenile delinquents are emotionally disturbed or not should be moot since it has little to do with the problem being discussed here. The line staff of the YDC's are capable of working with the socialized delinquent. Treatment problems revolve around an entirely separate group of acting out or uncontrollable youth who do not fit into the YDC system.

5. In general the staffs of the individual YDC's are well trained and act as competent therapists. They do not have expertise in treating, and feel uncomfortable in working with, emotionally disturbed adolescents.

6. The severly acting out emotionally disturbed resident presents a dissident force in a unit. He takes up too much individual staff time and distracts them from the group. This in itself may generate great resentment from the staff and thus promote greater acting out.

7. Most YDC staff ask for psychiatric help in dealing with emotionally disturbed residents. They mean various things: (1) create a special treatment unit; (2) get a better response from the local MH/MR Center; (3) have the state hospital handle the problem; (4) get more psychiatric input.

8. The way the emotionally disturbed delinquent is treated within the individual YDC depends to the greatest degree on its local staff and their concepts of therapy. Thus in one place drugs may be employed greatly and in another place minimally. In one place isolation is a major modality and in another place is forbidden. This also depends on the type of psychiatric consultation available.

9. Guidelines for prescribing psychiatric treatment are individualized to the unit YDC. Supervision of psychiatric personnel has not yet been established. Thus drugs may be prescribed in high doses without close monitoring in one YDC while, in another, automatic stop orders are the rule.

10. Staffing patterns for psychiatric input vary widely from full time availability to none at all.

11. Positive community response to the mental health needs of the local YDC is felt to be little by the staff, leading to difficulties in dealing with emergencies.

12. The YDC staff has expressed concern over the attitudes of the adolescent units in State psychiatric hospitals towards YDC residents sent for treatment. They would like closer communication between them and the psychiatric unit.

Recommendations

These recommendations should be regarded as preliminary and as a first step towards solving a chronic and pervasive problem. They will require discussion and development in order to activate them effectively.

1. An accurate count of the numbers and percentages of emotionally disturbed adolescents in the YDC's must be obtained. The figure is essential for program planning

and for deciding the amount of psychiatric input necessary. We are already in the process of looking for ways to begin such a study. Funds might come from an NIMH grant, from LEAA, or be funded through DPW.

2. Establishment of special psychiatric residental treatment units within YDC's should not be considered since they may be both counter-productive and create more problems than they can solve. These problems would revolve around: (1) staffing problems, (2) problems of assignment to the unit, (3) increased costs, (4) segregation and stigmatization of youth assigned to them, (5) loss of peer pressure toward more normal behavior.

3. Liaison between the Office of Mental Health and the Office of Social Services should be continued and strengthened, perhaps through creation of a permanent position with support. The position would be utilized to implement the following recommendations.

4. Increasing the amount of psychiatric input for the YDC's that require it. This can be done by making arrangements with qualified local psychiatrists and by working with the area medical schools.

5. Provide in-service training and supervision for psychiatrists who participate in the treatment of the residents. This may also be extended to diagnostic units and community programs. We are already negotiating to provide psychiatric coverage to the Philadelphia YDC from Jefferson Medical College.

6. Establish guidelines for the use of treatment modalities in the YDC system through a well thought out set of regulations to be prepared by the psychistrists in the system chaired by the liaison person.

7. Create better relations with local mental health units in the YDC area for use in emergencies. This would be done by personal contact and discussion.

8. Develop a closer working relationship between State hospital adolescent units and YDC's so that joint planning can be instituted for each problem case. This again may be the designated responsiblity of the liaison person. This may have to be preceded by visits to State hospital adolescent units to ascertain their capabilities to cooperate in such a program. It is possible that they may have to be assisted to create new therapeutic systems which have been shown to be successful in handling emotionally disturbed acting out adolescents.

9. Each YDC has individual diagnostic and treatment systems which are excellent. Integration of the best of them throughout the system by use of seminars and training should help increase the potentials for accurate diagnosis, development of treatment plans, and organization of methods to carry them out effectively and successfully.

10. Consideration of the establishment of an adolescent forensic mental health center to study emotional problems of juvenile delinquents and test ways of treating them. This would be a research team, not a physical treatment center, which would use grants to study emotional problems of juvenile delinquents, the relationship between the two problems, ways for effective treatment, and other new programs.

Conclusion

The preliminary study of mental problems of adjudicated adolescents has shown the existence of a large but unnumbered group of emotionally disturbed delinquents. The staff of the system has asked for help in handling them. Recommendations for beginning to understand the problems and to find ways to solve them have been provided.

Harold Graff, M.D.

Appendix D

SURVEY OF ADOLESCENT MENTAL HEALTH UNITS IN STATE HOSPITALS

Introduction

The Commonwealth of Pennsylvania maintains several systems for the care, treatment and rehabilitation of adolescents. These systems are mandated under different legislative acts and are administered under distinct divisions of the Executive Branch, depending on the presenting situation. The two principal Departments are Justice, for disposition of adolescents who are adjudicated as juvenile delinquents, and Public Welfare for their treatment. The Department of Public Welfare has at least three offices directly responsible for treatment after placement, and in situations where Justice is not the initiator, it acts as the initiating agency.

Decisions for placement depends upon a combination of factors: the initiating agency, the availability of appropriate facilities, and the subsequent behavior of the adolescent within the institution. Such decisions are legally regulated; they depend upon the nature of the deviant behavior of the individual delinquent, psychotic, or retarded each of which is governed by its own set of laws and civil rights. Once placed, however, the adolescent who is mentally ill comes under a different paradigm from the above, the medical or therapeutic, in which the significant concerns are diagnosis, etiology and treatment of the individual. In mental health settings, deviant behavior is viewed as a symptom, or a result of controlling causes, social, emotional or physical.

Whatever the causation, a common expression of adolescent deviation is the term, "acting out," which has come to mean deviant behavior of any kind as a way of solving emotional problems. It does not include deviant behavior which is sanctioned by a deviant subculture. Another common expression is "emotional illness," a condition which may also express itself in acts which are prohibited by law. Because both severe emotional disorder and the commission of delinquent acts may often be present in the same individual, what is recognized first or is most salient will often determine whether the adolescent will be adjudicated and sent to a YDC, or committed and sent to a mental health facility.

The numbers of youth who manifest both deviant behavior and psychosis have been shown to be increasing in the population. A recent survey conducted in the Youth Development Centers documented this rise and found that the YDC's do not have the facilities, expertise, and staff training to cope with mental disorders. At the same time, clinical experience seemed to suggest that the psychotic or severely emotionally disturbed adolescent who was also delinquent was unwelcome in the Commonwealth's Mental Hospital Adolescent Treatment Units. This created a group of youth who "fell between the cracks," too delinquent to be treated in a hospital setting and too psychotic to be rehabilitated in a correctional setting. The survey of the YDC's identified these youths as manifesting behavior characterized as violent and destructive, usually paroxysmal. Since the survey had concluded that the YDC system was unable to handle such adolescents, it became evident that a companion survey of adolescent units within State hospitals was required to determine their ability to accept such an adolescent.

Authorization

The survey was authorized by the Deputy Secretary and Commissioner for Mental Health, Robert M. Daly, M.D., and sponsored by the Director of Children and Youth Services, H. Allen Handford, M.D. Principal surveyor was Harold Graff, M.D., Director for Youth Services Liaison, Office of Mental Health. At the request of Gerald Radke, MSW, Deputy Secretary for Social Services, Horace Lowell, MSW, Director of Research, Division of Youth Services, Office of Social Services, was invited to participate in the survey.

Each hospital visit was preceded by contact with appropriate authorities, the directors of units, hospital superintendents, and regional commissioners. In many cases the surveyors were known personally to the unit directors and superintendents, which facilitated openness and exchange of ideas and concepts.

Method

Each hospital was contacted personally prior to visit. The list of hospitals under the auspices of the Office of Mental Health was divided as to follows: (1) hospital containing adolescent units, (2) hospitals not containing adolescent units, (3) special adolescent hospitals.

Hospitals with Units

Southeastern Region

1. Haverford State Hospital
2. Norristown State Hospital

Western Region

1. Warren State Hospital
2. Woodville State Hospital

Hospitals without Units

Southeastern Region

1. EPPI
2. Philadelphia State Hospital

Northeastern Region

1. Allentown State Hospital
2. Farview State Hospital
3. Clarks Summit State Hospital
4. Retreat State Hospital
5. Wernersville State Hospital

Central Region

1. Danville State Hospital
2. Somerset State Hospital (a) Hollidaysburg Annex
3. Harrisburg State Hospital

Western Region

1. Mayview State Hospital
2. Dixmont State Hospital
3. Torrance State Hospital

Special Hospital

1. Eastern State School and Hospital

Hospital Visited

Hospitals with Units — All

1. Haverford State Hospital
2. Norristown State Hospital
3. Warren State Hospital
4. Woodville State Hospital

Hospitals without Units — Five

1. Philadelphia State Hospital
2. Allentown State Hospital
3. Clarks Summit State Hospital
4. EPPI — Familiar to examiner
5. Mayview State Hospital

Special Hospital

1. Eastern State School and Hospital

Haverford State Hospital

This Unit was visited alone. I was able to have both a discussion and a tour. The Unit was described by Drs. John Fong, Superintendent; Nicholas Simon; and Diane Pearson. The Director, who could not attend, is Bernard Kanter, M.D. He is trained in child psychiatry; his position is a half-time one, but it is supported by five other physicians, Drs. Diane Pearson, Ora Smith, Carl Hammer, Marie Marcovic and Robert Fenichel.

The Unit can accommodate 20 patients, which is an optimum size. The numbers of psychiatrists attached to it means that each patient can have his own therapist assigned. Census at the time was 18 for a vacancy rate of 10%. Thus, psychiatric staffing patterns are adequate.

Adquacy of staffing does not follow through to nursing coverage. A trained psychiatric nurse covers the day shift, but sometimes one is not available for the evening shift. Staffing patterns for psychiatric aides leave much to be desired. Since the divisions of the hospital are not unitized for trained staff, aide assignments are varied and lack therapeutic continuity. This situation is the result of staffing complement difficulties. The Unit does not have a full time occupational therapist or recreational therapist, considered desirable both by administration and by present standards for such units. The current pattern of one full-time R.N., 3 day attendants and 3 night attendants does not meet acceptable standards suggested by adolescent psychiatrists.

The program consists of education provided by the Delaware County Intermediate Unit with ancilliary activities planned by the Hospital Occupational Therapy Unit and Recreational Therapy Unit, which are shared with the rest of the hospital.

The unit accepts both boys and girls who are housed on one unit but in separate sections. The program is designed for adjustment reactions of adolescence and mild behavior disorders with underlying diagnoses of borderline syndrome. Those who do not fit into the program are referred to Eastern State School and Hospital: this generally applies to adolescents with a diagnosis of schizophrenia. Referrals from Youth Development Centers are refused as being too unmanageable for the Unit. This is justified by the lack of security and insufficient staff-patient ratio.

The therapeutic program includes family therapy, but only one social worker is available so that not all families can be included. The worker tries to initiate discharge planning, but there is little on-going liaison with the County MH/MR Base Service Unit before discharge.

Modern concepts of a "level" system are used for therapy and behavior control. Adolescents who are too disruptive are referred out of the Unit. Average length of stay is three months. The Unit seems to function peacefully because of the selection process. Drugs and sexual acting out seem to be minimal. It is interesting that a passive-compliant type of patient is selected.

The Superintendent feels that 20 adolescents are all that can be handled adequately while others believe it could be expanded to 24. While this may be so if selection is careful, the Unit is not equipped to handle patients with severe behavior or psychotic disorders.

There was concern about the designation of the Unit as a referral center for the Central Region. It was argued that adolescents whose homes are too distant for families to participate would experience double the average length of stay and would downgrade the Unit service.

The consensus is that the Unit should have a partial hospital program and a halfway house connected with it.

The constant concern of the staff is lack of adequate personnel, staffing assignments that preclude continuity of care, and lack of adequate provision for activities, all deemed necessary for proper treatment of adolescents. This is based on the longer length of stay for adolescents with the borderline syndrome and current treatment requirements. They mentioned the destructiveness of such patients, requiring more funds for maintenance, and the lack of facilities for patients to work off adolescent energies (a gym, a pool).

The physical unit itself is neat and clean, but lacks warmth and friendliness. It has two quiet rooms, one of which requires re-construction to insure that patients are not able to injure themselves.

My impression of the Haverford State Hospital Unit is that it selects its patients carefully, choosing patients who are moderately easy to manage but also showing a deep level of psychiatric illness. The borderline syndrome patient needs to be hospitalized for many months for the experience to be successful. The staff is dedicated and proud of their work. There are enough psychiatrists but not enough support staff to back them up in the important therapeutic work that goes on between therapy sessions.

Norristown State Hospital

I visited the Hospital without any others accompanying me. I was able to interview the Superintendent, James Harris, M.D., the Assistant Superintendent, Dorothy Cleaver, M.D., and the Director of the Adolescent Unit, Margaret Conrad, M.D. Dr. Conrad is a child psychiatrist.

The Norristown Unit serves a wide area of the Southeastern Region and has room for 10 patients. The Director views herself as a combination of administrator, program director and treatment team leader. She receives good support from the Hospital Administrator. The staffing pattern is different from that of the Haverford Unit. Here there is only one psychiatrist but more aides, 14, who perform the one-to-one therapy. Again, there are few psychiatric nurses, one full-time and one part-time. There is one part-time activities worker and no occupational therapist.

The Unit has only 10 beds and the call for admissions may be greater than it can accommodate. At the time of the visit there were five adolescents placed on other Hospital units. The Unit is not viewed by the Hospital as a comprehensive Unit for all adolescent problems. Its size, staffing pattern, and facilities are seen as adequate for passive depressed youth or schizophrenics, not for severe acting out adolescents or those with behavior disorders. It functions as an open unit during the day but is locked at night.

It is usually filled and has a waiting list. This is

attributed to a high length of stay because of the lack of pre-discharge planning in cooperation with other agencies. Adolescents with criminal behavior are felt to be unmanageable on the Unit and are not admitted.

The Administration believes that it could treat a larger group if staff were increased, even if patients were housed on adult wards (this has proved successful if staff is assigned specifically to the adolescents who meet for program during non-sleeping hours). The lack of staff is felt especially in nursing.

The Unit has a full time social worker, who is able to handle family diagnostic interviews, family therapy, and a parent group.

The Education Program is provided by the Montgomery County Intermediate Unit and includes classes for adolescents who are able to live at home.

Average length of stay is 12 months.

The physical unit is bare and sparse. It is not adequately set up to house adolescents. There are two seclusion rooms.

A level system is utilized in daily behavior managements. The therapists feel a need for a day program and halfway house. They feel the lack of resources for pre-discharge planning and for a community resocialization program.

The program is fortunate in having a swimming pool and a gym for recreational therapy.

The Norristown Unit is small, adequately staffed with a full-time psychiatrist, social worker, and aides, but lacks adequate nursing coverage. It could expand, but would require more personnel and special therapies experts not now available on the hospital staff.

Warren State Hospital

The Adolescent Unit was visited during the meeting on forensic psychiatry. The Hospital serves a large area of northern Pennsylvania and is at a considerable distance from the small urban centers of the region. Even so, it accepts patients from much of the region.

Its Director, Roger Mesmer, M.D., was functioning on a part-time basis, and, at the time of the visit, was planning to turn over the Directorship of the Unit to a new full-time Director. Dr. Mesmer had planned to give concrete support to the new Director.

The Unit itself, like Norristown, is a small one, accommodating eleven adolescents. The Unit is mixed for sexes. It is usually filled. It could expand to take more patients, but this would require more personnel. The possibility of serving additional clients would also require new construction to meet current standards for treatment of this age group. Staffing deficits are especially noticeable in the area of education and recreation.

The staffing problem is difficult in the now recognized areas of education, occupational, and recreational therapies. Classical one-on-one therapy on an individual basis is well provided by available staff.

The building is old and not properly designed for adolescents. Especially noticeable are the numerous structural components that adolescents can use for self injury.

Warren State Hospital Unit is a small Unit that is faced with referrals from courts and YDC's of difficult adjudicated adolescents. They feel themselves in a beleagured position but try to accommodate all other agencies. They find this difficult to do because of size, structure, and lack of personnel.

Woodville State Hospital

The visit to this Unit was made with Horace Lowell, MSW, representing the Youth Development Centers. This Unit, now 10 years old, is directed by George Zitner, M.D., who has headed it for 8 years. He is a qualified child psychiatrist.

This Unit is the largest for adolescents in the system, excluding Eastern State School and Hospital. Its census at the time of the visit was 30, although it has been as high as 44.

The Unit is well staffed, with two psychiatrists (although three would be ideal), 34 nurses and aides plus a head nurse, two social workers, and two recreational therapists. It also has an administrator. While the staffing pattern holds the best ratio in the system, it is just adequate. It should be considered a model for other units.

The Unit requires much physical renovation work and is not up to standards suggested by present authorities.

The Unit admits by approval of a staff admission committee which selects patients appropriate to the Unit. Those adolescents who do not meet adult diagnostic categories for admission may be placed on the general units of the Hospital. The Unit is integrated in its therapeutic system and is not designed to treat retarded or severely psychotic patients, or patients with behavior disorders. Ninety-five percent of the admissions have come, however, from other facilities. Thus, this Unit, while selective, functions as a tertiary care facility.

An important issue for the Unit is that they do not view themselves as an emergency unit, but as an intermediate long term and therapy program, which in line with the concepts of tertiary care and of selecting those who can best benefit from their program.

Current concepts of adolescent treatment stress group participation, group and peer therapy. Those patients who cannot function in a group setting, whether too regressed or too violent, do not function well in the Unit.

Each adolescent is afforded the services of a psychologist (the Unit used to have two).

Average length of stay is eleven months, although it may range to twenty-four months. They have few short stays and few sign outs. Families are encouraged to enter treatment with the two social workers and psychologist.

The Unit functions on a level system with group cooperation on a family style. Activities are fostered but not funded. The staff is prohibited from soliciting donation of funds for this form of therapy, but the community is aware of the need and often provides it.

In summary, the Unit is a large, well managed, fairly adequately staffed treatment center that meets standards for treatment of adolescents. It can handle large numbers (30-44) because of its staffing pattern and good selective policy.

Hospitals Without Adolescent Units

These hospitals will be discussed as a unit with special attention paid to Mayview State Hospital, since its situation is viewed by its staff in such a way as to render its viewpoint different from the others.

The group of hospitals surveyed that do not have an adolescent unit hold to the same position, that they are not capable of admitting adolescents and therefore do not feel they can treat such patients. Those surveyed service a large area of their regions, yet they have few calls for admission. They state that they have no services for treatment of this group and cannot offer appropriate therapies. They have developed strategies for community placement of referrals, which are viewed as effective.

In general, their evaluation of their situation is correct. They do not have staff skilled in the treatment of youth or programs which are necessary to effect such treatment. This position is in line with the view now held that adolescents are neither adults nor children and require age-specific methods of therapy. Most are prepared to handle an emergency admission on a mixed or adult ward, but immediately work toward a re-referral.

For the most part, those interviewed were senior therapeutic and administrative staff. They did not rule out the possibility of the addition of adolescent treatment units. Their feeling, which I view as consistent with reality, is that they would require additional staffing, new specialized personnel, and additional consultation in order to treat adolescents.

Mayview State Hospital presents a separate situation. It has developed an outstanding children's unit which accepts age appropriate patients for definitive therapy. It is located close to the largest adolescent unit in the system (5 miles) and has a referral place for those who are too old for its child unit. Attempts at communication and cooperation between unit directors at Mayview and Woodville are ongoing, so that duplication of services would be inappropriate. Liaison between the Children's Unit at Mayview and the Adolescent Unit at Woodville is encouraged and supported.

Eastern State School and Hospital

Eastern State School and Hospital is a large, integrated adolescent treatment center led by a nationally known child and adolescent psychiatrist. It functions in a manner distinct from other State adolescent facilities. Its numbers of staff and patients necessitate a separate survey not consistent with the aims of the present study. Its population is changing and the demands placed upon the staff are evolving. I would recommend a comprehensive team effort in cooperation with staff and administration if such a study is deemed necessary (see p. 52 below).

Brief Summary and Commentary

Excluding Eastern State School and Hospital, a large facility, the majority of the State Mental Hospitals do not have proper capabilities for treatment of adolescents. This means that, as far as this system is concerned, treatment close to home, where community and family resources can be brought to bear, is generally not available. The principal reason is the lack of trained personnel: there is a dearth of people who know how to deal with this age group, and current funding and hiring realities reinforce this shortage, so that the State Mental Hospitals are not now prepared to form adolescent treatment centers.

The four hospitals with units (exclusive of ESSH) are usually organized as specialized treatment centers for youth who cannot be managed by community based or short term facilities. Within the limits of the staff available to them, funding, and physical facilities, they do an excellent job. Their staff is uniformly directed by well trained therapists and supported by diligent people who understand the specifics of adolescent therapy. What they lack as individual units is a full complement of staff both in numbers and in specialized treatment skills to promulgate a complete treatment program.

The numbers of beds available in these units is surprisingly small, approximately 85, which is less than are available privately in Philadelphia. As noted before, the units are not completely filled. This appears to be created by a reverberating effect. If the service is not offered openly or not seen as available, it may be underutilized.

On the other hand, underutilization may be of benefit to those patients who seek the service. As noted above, minimal staffing and less than maximum programmatic availability require a highly selective admission policy that chooses only those (1) whom the system can best treat, and (2) who will not disrupt the therapeutic milieu (a position taken by almost all adolescent treatment centers). Of necessity then, violent patients, severe schizophrenics, and any other patient who cannot work within the provided milieu are not acceptable if these treatment units are to survive. This policy necessarily excludes the psychotic violent juvenile delinquent who also cannot be treated in a Youth Development Center. It also accounts for those delinquent emotionally ill youth who "fall between the cracks."

The adolescent units see themselves as providing good therapy for those who require long term inpatient therapy not able to be provided in the community. Willing and able to accept more patients who fit into the program, they are concerned about placement distant from families, a very important consideration in the total treatment of adolescent patients.

Each unit director and/or superintendent who supports a treatment center expressed the desire to offer more expanded services. They deplored the lack of specialized treatment facilities for the more violent emotionally disturbed youth and desired to add such programs to their organization. They recognized that it would require proper housing in a more secure structure, a staff in sufficient size to meet standards for such care, selection procedures of staff that would identify people who are equipped to treat such a group, and adequate funding to secure the plan. They recognize that the probabilities for creation of the units are slim, but the desire is there if programs are capable of being organized.

Discussion

When one excludes ESSH from consideration of the total complement, one sees that the general state hospital system that provides services for the adolescent who requires tertiary care is small, ranging from 71 to 85 beds. We should consider whether the system provides enough bed capacity. Several issues must be recognized.

In viewing the total picture, it should be stated that adolescents who need treatment for emotional disorders have available both the public and private sectors. The private sector is extensive, and in contrast to tertiary care as provided by the units studied, is larger and more complete. Examples of this within the Southeastern Region alone are the units at Friends Hospital, Institute of the Pennsylvania Hospital, and Horsham Hospital. Their capacity almost equals that for the total Commonwealth system. In many cases these hospitals act as a complete therapeutic system, including emergency short term care, secondary intermediate care, and long term tertiary care. The state hospital system has to be judged against its parallel in the private sector.

The public sector as represented by its components is multivariate. It offers in large measure the same tripartite system as the private sector, with emphasis on the first part, the primary care system. The primary care system is represented by the Mental Health/ Mental Retardation Organization, the Base Service

Unit. It is oriented to short term crisis care on an outpatient basis with brief follow-up. It has as its back-up the local state or private psychiatric hospital for emergency in-patient treatment. If long term therapy is required, then the State mental hospital adolescent units in the Western and Southeastern Regions provide the tertiary care. Normal rates would suggest that each system would be progressively smaller, but this does not prevail. Our review suggests several reasons for this: (1) there is less than optimum communication on individual cases between the various parts of the system; (2) staffing realities limit the general clinical services of State mental hospitals without adolescent units and therefore lead to their not accepting adolescents; (3) the prevailing attitude is that adolescents are unacceptable for treatment within the State system except in special units; (4) fiscal and legal realities keep existing special units small; and (5) the result is a need for stringent selective policies for admission. What results is a small, highly refined, excellent, highly selective system that functions well within its boundaries but is not provided with the wherewithal to service a large or non-selected population. If it is true that the private sector is larger and less selective, then the present system must be re-evaluated. This would require a study beyond the scope of the present one.

Other issues make the necessity of examination a primary issue. Examination of the population within the facilities serving youth in Pennsylvania (excluding retarded) leads to the impression that clearcut diagnostic entities are disappearing. At one time the Youth Development Centers treated non-psychotic delinquents, especially those who were socialized. On the other hand, State Mental Hospitals handled the psychotic, non-acting out youth. The borders now are manifestly less distinct, with both systems seeing an amalgam of the two groups. Both systems complain of their inability to handle the new psychotic acting out, delinquent adolescent. It is not our purpose to explain this phenomenon, but only to report its occurrence. What happens is that the State mental hospital system has neither the trained staff nor the expertise to handle a disruptive delinquent psychotic teenager, while the Youth Development System has no personnel to cope with clients with a severe emotional disorder. What then occurs are adolescents who are acceptable to neither system and so do not receive adequate services in either.

Recommendations

Recommendations listed here stem solely from clinical considerations and follow the suggestions of directors and superintendents interviewed. In all cases the desire was for expanded services to the delinquent acting out youth. They envisioned this as functioning through closed secure units, though not on the level of maximum security units of Cornwells Heights and New Castle YDC's. They saw these units as both necessary and impossible to obtain because of fiscal and staffing restraints. They were also aware of the difficulties presented by laws which fail to recognize adolescent deviant behavior as unitary, but see it as either based on criminality *or* emotional disorder, to be handled separately, never together. They recognized their own expertise and were prepared to offer their services if adequate support was provided.

My experience as a clinician leads me to concur with the above suggestions. It was my impression that present currents outside the system have kept tertiary adolescent services small. Proper treatment on an active basis requires a certain number of treaters per treated. Clinical wisdom has shown that for adolescents, the necessary ratio is high in terms of numbers of treaters per patients. If the number of personnel available is small, then the numbers of patients are small. Also, the more violent and agressive the patients, the larger is the staff needed to treat them. Small staff means less patients and less difficult patients in terms of overt acting out. For these reasons, the prevailing situation keeps the system small (exclusive?) and out of the public eye. The result is a low level of referral. The low level is fortunate because currently the system cannot handle a high level of referral.

Summary

A study of adolescent units within State Mental Hospitals has shown that the units are small and function with limited personnel. The hospitals that have such units are distinguished by a high level of support by the administration for such units and an excellent staff. Those hospitals without such units feel appropriately that they have no ability to treat adolescents and either refuse to accept them or refer them out rapidly.

Units in existence are restricted in the number of staff they are permitted to hire and in many cases have problems in finding staff with training and ability to treat adolescent patients. These problems provide limitations in the type of patient who can be admitted.

Of special concern is the rise in the delinquent emotionally disturbed youth. All who are involved in

their treatment seem to be moving toward the concept of combined units. These units would be secure, working on the level system. Team approaches combining the best of social services and mental health services would be developed.

I am aware that I have presented more issues, or problems, than recommendations. Clinically, the recommendations are soundly grounded in the requirements for adequate treatment. They may, however, be beyond the scope of availability when measured against the policy of providing general services at minimal cost as opposed to specific services tailored to the needs of one sector of the population.

EASTERN STATE SCHOOL AND HOSPITAL

Eastern State School and Hospital (ESSH) is the largest State psychiatric hospital for children and youth in the Commonwealth. Its organization and function are distinct from other State run adolescent units in that it does not treat any other age group. Information concerning ESSH was gathered from discussions with administration, staff, and from personal observation.

The administration views the capacity as flexible, reporting it as approximately 200. At the time of the survey, the census was 160 (80%). This, however, can vary from day to day. Estimated rate of adjudicatible delinquent behavior was 12%.

In assessing ESSH, it is necessary to keep in mind that there will usually be no legally adjudicated youth among its clients. The staff is sensitive to the fact that only patients admitted under the Mental Health Act (No. 143) are eligible under law to be retained as residents. A youth ordered to be sent for admission is first examined in the diagnostic unit. Several possibilities exist.

1. If he is sent to ESSH under the Delinquency Act
   a. and found delinquent, he is sent back to court for appropriate placement,
   b. and found emotionally ill he is sent back to court for recertification under the Mental Health Act and treated by ESSH.
2. If he is sent to ESSH under the Mental Health Act
   a. and found delinquent rather than mentally ill, he is sent back to court for appropriate placement,
   b. and found emotionally ill he is retained for therapy.

It is thus the policy of ESSH that patients be retained only under provisions of Act 143.

Current status of patients are listed as:

1. 60% involuntary commitments
2. 40% voluntary commitments

ESSH views itself as able to treat almost any, but not all, children and adolescents. They feel that they cannot handle the overly large, overly sexual, overly aggressive older teenager, from ages 16-18. This restriction is not a severe one, since they have developed the capacity to handle an aggressive, acting out, non-psychotic, but emotionally ill adolescent in a special closed unit. The unit provides a highly structured program, including school maintained within the unit. Any youth who cannot function in this unit will be sent to court for another placement. This unit is for males only. The experience of ESSH is that the delinquency rate in the male population is higher than female by a 4:1 ratio. Interestingly, ESSH reports that an approximate rate of delinquency and psychoses combined is 5%, seven or eight adolescents per year, although the rate of psychoses in the Hospital population averages 20%.

The current program consists of fourteen units, of which six are closed and eight are open. The closed units are designated as such because they are locked. They are not designed as security units. Moreover, the staff, while adequate, is not appropriate to treat the large, aggressive teenager, whether psychotic or non-psychotic. Many are women, middle-aged, not trained to cope with aggressors.

The staff complement lists 13 psychiatrists, approximately 40 nurses, with at least one on every shift. The complement of aides is also adequate, with four on days, five on evenings, and two on night shifts. Appropriately, staff is not shifted from unit to unit. A physician is on the premises at all times.

Staff is uneasy about the possibility of dangerous or aggressive behavior. They would like to have more males in the complement, including the girls unit.

The staff continues to be concerned about an adolescent whom they see as delinquent although committed as emotionally ill. They express the feeling that it creates anger and hostility in their group because

of the demand on staff time. They feel that it becomes necessary to devote large amounts of staff time to behavior control of one or two youth, when they see their time as better spent treating the emotional disorders they feel they can help. Staff especially becomes demoralized by their inability to cope with violent girls. The therapeutic concept of ESSH is based on the milieu; disruptions of milieu are thus hard to handle if the individual client does not actually belong in it. The staff requires close emotional involvement with their patients. Anyone they fear is rejected. Staff is also concerned about the impact of the aggressive and violent adolescent on the more passive and dependent child.

Staff recognizes that their male population will usually show delinquent behavior. Diagnostic workshop is designed to determine which is primary, delinquency or emotional disorder. One problem concerning judicial placements to specific units is related to how ESSH organizes itself. Its program is divided on the basis of developmental level. Thus, placement is based on age, size, and emotional maturity. A forensic unit, as such, would be dissonant to their organized therapeutic concept.

A theme running through the discussions was concerned over aftercare. Staff did not believe that contact with Base Service Units was adequate, often non-existent.

The impression that ESSH gives is that it is a large adolescent psychiatric hospital, correctly broken up into appropriately sized and populated units. It recognizes delinquency as part of a syndrome of emotional disorder and is prepared to treat it if it is a symptom of the emotional disorder. It is not structurally or organizationally set up for the rehabilitation of either the true delinquent or the overly aggressive youth. This should not be construed as a recommendation against such admissions. If ESSH should be considered as a placement for the highly aggressive, emotionally disturbed, delinquent youngster, it would need appropriate staff and correct physical structure.

Harold Graff, M.D.

SURVEY OF PRIVATE ADOLESCENT PSYCHIATRIC TREATMENT CENTERS COMMONWEALTH OF PENNSYLVANIA, 1978

1. Number of facilities: eight

2. a. Beds specifically for adolescents – 123

   b. Beds unspecified but may be used – 57
   for adolescents

   Total 180

3. Beds by region

Southeastern	113
Central	57 – unspecified
Western	10
Northeaster	0

4. Listing of identified hospitals

Hospital	Region	Bed number	JCAH approved (for adolescents)	Accepts adjudicated youth
Eugenia	S.E.	20	No	Yes
Friends	S.E.	21	No	Yes
Horsham	S.E.	22	Yes	Yes
Institute of PA Hospital	S.E.	24	Yes	Yes
Northwestern Institute	S.E.	10	No	No
Philadelphia Psychiatric C.	S.E.	16	No	Yes
Philhaven	Central	57	No	Yes
St. Francis	Western	10	Yes	Yes
		Total 180	Total approved 3	

5. Eugenia Hospital accepts adjudicated youth but does not specify any numbers. It does have a closed unit. Sexual mix — 10 male beds and 10 female beds.

6. Friends Hospital will accept adjudicated youth. It currently does not have an adjudicated adolescent in the Hospital. They reserve the right to be selective in admissions policies, taking only a patient who, after diagnosis, will benefit from their program. No limits on numbers of sex.

7. Horsham Hospital accepts adjudicated youth, both male and female. They do not restrict the numbers up to their capacity of 22. They judge each situation individually and if they believe they can help an adolescent, they will accept him regardless of status. See below for special project.

8. Institute of the Pennsylvania Hospital will accept adjudicated youth. They accepted 3 in 1977 and 1 in 1978. They accept a greater number of pre-adjudicated youth. They will exclude an adolescent who cannot cooperate within a written treatment contract.

9. Northwestern Institute does not take adjudicated adolescents.

10. Philadelphia Psychiatric Center's adolescent service was not filled at the time of the survey. It has a capacity of 8 male beds and 8 female beds. Current census was 3 males and 7 females. Their experience with adjudicated youth is very limited. They report 2% of admissions adjudicated or pre-adjudicated.

11. St. Francis General Hospital accepts adjudicated youth. 20% of admissions in past two years have been in this category. It is a closed unit.

12. Philhaven does not have an adolescent unit but accepts adolescents. They cannot identify the exact numbers but state as follows:

> A number of youth have varied involvement with the Judicial System. Some have had no involvement with the courts while others have become involved in treatment in lieu of court sentencing. Adjudicated and pre-adjudicated youth would be accepted into the Hospital treatment program dependent on the availability of beds.

13. Potential for service to emotionally disturbed adjudicated youth by private inpatient adolescent treatment centers is limited:

    a. No facility has a security unit.

    b. Number of beds are limited. The figures suggest that the experience of this group is severely limited in the treatment of adjudicated adolescence.

    c. Given the much higher ratio of male to female adjudicated youth, beds are limited by the fact that some units keep a strict 1:1 ratio of male to female beds.

    d. Two units, and for practical purposes, a third with most of the beds, exclude adjudicated youth. A fourth, Philhaven, does not have a designated unit. This leaves a total number of beds available as 97. Practical experience suggests it will be much lower, based on the individual hospital's needs.

    e. Each unit reserves the right to select patients who fit into their treatment program. They usually will not accept the overly violent or non-controllable youth. In this they are very much in conjunction with mental health units in the public sector.

14. Horsham Hospital has been granted funds by LEAA for a unit to treat adjudicated adolescents. It will have a capacity of 15 beds. It was not yet in operation at the time of the survey. It will add materially to the number of beds available to treat mentally ill adjudicated youth.

15. LEAA would like to fund a facility in the Western Region and would accept a qualified applicant.

16. In conclusion, the private sector is not now an available resource for the treatment of emotionally disturbed adjudicated adolescents. Plans are under development to make it so. The Task Force might go on record as advocating such cooperation between government and the private facilities, supporting current plans and advocating further ones.

Harold Graff, M.D.

Appendix E

SHUMAN CENTER PROJECT

As a consequence of a major two-year study (1974-1976) into the nature of the juvenile population brought to the Allegheny County Juvenile Court and the human services provided to and required by this population, conducted for the Task Force of the Allegheny County Juvenile Court/Western Pennsylvania Regional Office of Mental Health, that Task Force documented the need for several proposals.

The first proposal called for the development of a new service for the comprehensive assessment of and program planning for juvenile offenders who require an evaluation because of their violent and agressive behavior and/or because they pose a complex diagnostic problem regarding their clincial and developmental needs. The second proposal called for the development of a facility which could provide maximum security for violent and agressive adjudicated juveniles who were not mentally ill, for the therapeutic containment of their behavior while receiving the multiple human services required by them for remediation of their developmental and clinical problems. The third proposal called for the development of a county wide authority, which would assume responsibility for monitoring the development of the components of a regional system of human services for all juveniles brought to the attention of the juvenile court because of alleged or adjudicated delinquent behavior.

With the support of the Office of Mental Health, Department of Welfare, the Regional Office of Mental Health, Western Region, and the Allegheny County Juvenile Court, a pilot project entitled the Shuman Center Project was undertaken by the Neuropsychiatric Assessment and Disposition Service of Western Psychiatric Institute and Clinic, of the University of Pittsburgh, in response to the proposal of the Task Force.

The Neuropsychiatric Assessment and Disposition Service (i.e., Shuman Center Project) represents an innovative attempt of relating the following to each other: the highly specialized expertise of an academic child psychiatric service; the juvenile offender who manifests violent and aggressive behavior or poses a difficult diagnostic problem, each requiring a comprehensive evaluation as the basis for a decision regarding the nature of services to be rendered; the need for an organized and designed system of data collection and analysis, to serve as a quality control linkage and monitoring vehicle for all juveniles evaluated; and the Juvenile Court, with its administrative services, its probation staff and detention center and their need for programs of staff development.

The Neuropsychiatric Assessment and Disposition Service (i.e., Shuman Center Project), of Western Psychiatric Institute and Clinic, was initiated in July, 1977. Following a process of recruitment of staff and the development of agreed upon procedures and criteria between the Shuman Center Project Staff and staff of Allegheny County Juvenile Court, the first patient was referred in November, 1977.

From November, 1977 to September, 1978, a total of 25 referrals from the Allegheny County Juvenile Court had been accepted for evaluation. More than half of these patients were currently charged with some type of assault. Six were to stand trial for crimes of a sexual nature, while two youths had been previously charged with this type of crime. Ten of the patients had been involved with a burglary or theft.

Twenty-one of the referred cases were male and only four were female. Although the range of ages of the patients is from 12-18, 52% of them were either 15 or 16 when they were seen by the project staff. The breakdown in terms of race shows that 14 of the cases were black (56%) and eleven (44%) were white. The range of the Full Scale I.Q. scores of our patients varied between 68 and 103. Seven patients scored below one standard deviation from the average I.Q. score.

None of the patients' developmental histories could be characterized as non-stressful. Fourteen of the cases show family histories of marital problems which led to divorce. Six adolescents were from homes where there has been a parental death. When not institutionalized one-third of the patients were not living with their natural parents. Only two of the adolescents seen by the project came from an intact family. Another indication of the very difficult family background from which these patients came can be seen in the high rate of child abuse and neglect. Nine patients or one-third of all the referrals seen by the Assessment Service were subjected to abuse and neglect by family members.

Twenty-five recommendations have been made so far by the Shuman Center Project. Fourteen of these recommendations include short-term inpatient care at

Western Psychiatric Institute and Clinic. Four patients were seen as needing more long-term inpatient care at a psychiatric treatment setting. These four were also recommended for trials of medication along with seven of the patients who were recommended for short-term inpatient care. Fifteen adolescents were seen as being able to benefit from placement in a residential facility either immediately or after a short-term inpatient placement at Western Psychiatric Institute and Clinic (nine cases). Due to their special needs in regard to education, fourteen patients received recommendations that included some type of individually designed educational program. In twelve cases, counseling was seen as beneficial for the patient and also in ten cases it was seen as necessary for their family. Treatment for physical problems was recommended five times, for conditions including anemia, gynecomastia, hypercalcemia, obesity, and rheumatic heart disease. In three cases the Project Team felt that the disposition of the child should be entirely in the hands of the legal system.

During this same period of time a program of weekly inservice training and bimonthly consultation has been provided to the direct care staff of the Detention Center. A detailed course outline has been developed and the School of General Studies of the University of Pittsburgh has granted undergraduate accreditation.

	Number of Patients	Percentage
Sex:		
Male	21	84%
Female	4	16%
(N=25)		
Age:		
14 and under	6	24%
15 – 16	13	52%
17 – older	6	24%
Race:		
Black	14	56%
White	11	44%
(N=25)		
IQ:		
Borderline Mental Retardation (FS – Low 80's and under)	7	29%
Dull average – average	17	71%
(N=24)		
EEG:		
Normal	11	52%
Abnormal	10	48%
(N=21) (4 cases unreported)		
Developmental History:		
Pre-natal and/or birth problems	5	20%
Child Abuse or neglect	9	36%
Parental Divorce	14	56%
Parental Death	6	24%
Not living with natural parent(s) when not institutionalized	9	36%
Enuresis	7	28%
Out of wedlock	3	12%

CHARGES BROUGHT AGAINST PATIENTS

	Case Numbers	
	Present	Previous
Simple Assault	1,9,12,13,17,21,24	8,13,10,21,24,25
Harrassment		3,24
Terroristic Threats	10,20	18,25
Aggravated Assault	5,16,23	5,18
Assault with a Weapon	7	13,18,20
Kidnapping		
Indecent Assault	3	
Rape	4,19	
Attempted Rape	11,22	
Attempted Sexual Attack		11
Involuntary Sexual Intercourse		
Indecent Exposure		9,20
Soliciting		15
Burglary	15	3,7,15,24
Breaking and Entering		9
Criminal Trespassing		7
Auto-Theft	2	
Retail Theft	14,18	19
Resisting Arrest		
Criminal Mischief		7,15
Receiving Stolen Goods		15
Malicious Mischief	8	8,15
Vandalism		3
Disorderly Conduct		
Truancy/Incorrigibility		16

Code:

ABNORMAL EEG's BECAUSE OF:

Name:		Reason:
Male – Case #1	–	Mild generalized slowing of age.
Male – Case #2	–	A diminution of normal rhythms.
Male – Case #6	–	Increased fast activity suggestive of sedative or tranquilizer drug intake.
Male – Case #7	–	Sharp and dysrhythmic appearance suggesting epilepsy or increased cerebral excitability of any other cause.
Male – Case #9	–	Due to increased cerebral excitability.
Female – Case #10	–	High voltage increased cerebral excitability and predominately left hemisphere spiked and wave discharge in the temporal lobe.
Female – Case #12	–	Increased cerebral excitability and bilateral spike discharge.
Male – Case #13	–	Due to a diminution of normal rhythms.
Female – Case #21	–	Due to spike and wave discharges.
Male – Case #23	–	Due to paroxysmal left temporal lobe discharges.

Appendix F

YOUTH DEVELOPMENT CENTER PROJECT
DEPARTMENT OF PSYCHIATRY
THOMAS JEFFERSON MEDICAL COLLEGE

Problem Statement and History

The Department of Public Welfare has succeeded, during the past five years, in implementing many of its goals and objectives for adjudicated delinquents. Institutional bed capacities have been substantially reduced; with LEAA assistance, a network of community-based alternatives has been established and community prevention grants have augmented local efforts to divert youths from the juvenile justice system. The State Correctional Institution at Camp Hill has been closed to juvenile commitments and several medium security units have been developed for the serious juvenile offender.

Numerous transitional strategies have created new concerns which must be addressed. The majority of disturbed and troublesome youths in the Commonwealth are now being diverted from institutional placement, but of those who are committed to the State's training schools, an increasing proportion are resistant to traditional modes of delinquency treatment. The emotionally disturbed, or "dual diagnosed," adjudicated delinquent is a prime example of this trend. His maladjusted behavior is symptomatic of a more primary behavioral disorder which has been neglected by the normal range of community services. A Yale study, cited in Lewis and Balla's *Delinquency and Psychotherapy* (Grune and Stratton, 1977), highlights the dilemma facing the courts and treatment agencies. The study demonstrates that there is often significant psychic disturbance in the parents of delinquent youths which may manifest itself only when the youths come to the attention of the courts. The study also showed that no less than 100% of the youths who committed homocide, or attempted to do so, displayed evidence of psychomotor epilepsy, a phenomenon that is frequently encountered by youth counselors. Further, brain damage, often resulting from childhood experiences, is more prevalent than many treatment personnel suspect. These findings indicate the critical need for intensive neuro-psychiatric and medical evaluations, (often not available from the judicial process), and treatment initiatives to address the changing nature of Pennsylvania's incarcerated juveniles.

Historically, the borderline, emotionally disturbed delinquent has been problematic for the Department of Public Welfare since the size and structure of its agencies have generally precluded intensive, professional treatment of this population. This type of client often becomes the victim of more mature youths in the youth service facilities, or if placed in a mental health institution, he frequently victimizes the more severe cases and disrupts programs while resisting treatment.

In March, 1977, the Offices of Social Services and Mental Health jointly arranged to have Dr. Harold Graff, an adolescent psychiatrist at Eastern Pennsylvania Psychiatric Institute, perform a preliminary study of the State's Youth Development Centers, to ascertain the incidence and degree of emotional disorders in those populations. Dr. Graff's study confirmed that a significant number of youths entering the juvenile justice sytem do manifest psychopathologies or emotional disorders. The Youth Development Centers and Forestry Camps cannot provide consistent, professional treatment in most cases, nor have local MH/MR facilities met this need. Directors at the YDC's complain that they cannot get adequate service for special cases, and Directors of the few remaining adolescent units at State Hospitals find that disturbed delinquents are usually beyond their capacities.

Dr. Graff found that estimates of mental dysfunction among the YDC populations varied, but that ample evidence existed to draw certain conclusions. First, the Youth Development Centers are receiving commitments that appear to be inappropriate. Second, some of the youths have had three or four prior psychiatric placements with little indication of success. Third, the youth facilities usually do not possess the resources to provide intensive comprehensive treatment for psychological symptoms. Fourth, this shortcoming sometimes result in the excessive use of psychotropic medication or detention and isolation. Fifth, requests from other service agencies usually go unanswered. Sixth, the issues are critical and demand further systematic analysis as well as program development and staff training.

In order to address these problems, (delineated above), the Offices of Social Services and Mental Health proposed an innovative project in DPW's Southeastern Region. The project developed from a

contractual agreement between the Philadelphia County Mental Health/Mental Retardation Administrator's Office, the applicable Youth Developmment Centers and a Base Service Unit.

For the current fiscal year the Department entered into a contract with Jefferson Medical School, Department of Psychiatry. The project is funded through the Office of Mental Health for this fiscal year.

The target population for the project consists of the total client capacities of the two Youth Development Centers at Philadelphia and Cornwells Heights. The former has a 10 bed girls' security unit, while the latter has an official capacity of 172 youths, who are all residential commitments. The total figure of 182 clients correlates to approximately 364 youths served per annum.

The Jefferson Project include a staff complement which is responsible for arranging comprehensive mental health services for those referred to it from the youth services system. The Project staff are to provide diagnostic and evaluation services, service plan development and case management, YDC staff consultation and training, arrangements for outpatient mental health services and placement services to avoid or reduce institutional commitments and provide essential post-incarceration care and service. Important secondary tasks include a research effort designed to achieve a needs and resource asessment and to monitor and evaluate the Project on a continuing basis. In addition, the Department is developing regulations and standards for the provision of mental health services in the Commonwealth's youth development system.

Introduction and Needs Assessment

A dramatic change has occurred over the past several years in the type of commitments received by the Youth Development Centers. It seems that only the most disturbed and troublesome youths are incarcerated in these facilities, while the less problematic ones are diverted elsewhere. This trend has led to a startling increase in the incidence of mental health and mental retardation disorders in the population of these centers. In fact, some youths are commited to these facilities directly from inpatient psychiatric units.

During the first four months of project operation, the following needs assessment was completed in order to determine how the above situation was affecting the Youth Development Centers in the Southeastern Region.

Need No. 1. Approximately 25% of the male population at Cornwells Heights and 50% of the female population at Philadelphia YDC have a history of MH/MR service prior to their incarceration. In the case of each of the females, this consisted of an extended psychiatric hosptialization. Incidents have been reported in which these adolescents have been involved in assultive, suicidal, and deviant sexual behavior while in residence. Because of this situation, these Youth Development Centers have repeatedly requested additional mental health support in the form of personnel, emergency psychiatric hospitalization services, and the eventual establishment of a special mental health unit on the Cornwells Heights campus. It is startling to note that prior to this project no mental health services were available to the girls at the Philadelphia facility.

Need No. 2. It is also been estimated that approximately 23% of the commitments to the Youth Development Center at Cornwells Heights are inappropriate. These cases instead should have been sent to a MH/MR facility. In many instances, these individuals typically remain in this facility where their needs are not met due to the lack of professional staff there to evaluate them and arrange for alternative placements.

Need No. 3. There is a growing need for staff development and training in these facilities. Presently, staff feel unprepared and untrained for working with the increasing number of emotionally disturbed youngsters arriving on their units.

Need No. 4. There is a need for increased continuity of care for emotionally disturbed adolescents when they are released from these facilities. Discharge recommendations are rarely implemented and the child usually returns home irrespective of the appropriateness of this setting for his

needs. Follow-up also does not occur and consequently, many of these adolescents eventually find their way back to the Youth Development Centers.

Summary of Resulting Project Activities

In response to the above findings, project staff have been involved in a variety of direct and indirect service delivery.

Clinical Activities

Case conferences have been initiated by project staff on each new admission to the Philadelphia facility. At this point a full treatment plan is written with goals and staff responsibilities for each girl being clearly specified. In order to assist in treatment planning, a full psychiatric, psychological, and sociological evaluation is also performed in designated cases. (These reports will be summarized in a future memorandum).

Project staff have also been participating in developing discharge plans at both Youth Development Centers. When appropriate, family counseling sessions are initiated in order to assess the level of functioning in the adolescent's family and to prepare them for his or her eventual return. Staff have also assisted four adolescents in finding placements other than their families upon their release from these Youth Development Centers.

In addition, a twice weekly group psychotherapy meeting is held at the Philadelphia facility. Line personnel at the center are rotated through these sessions as co-leaders, and thus, this group also serves an inservice training function for staff at this facility. Individual psychotherapy sessions have also been provided at both Youth Development Centers, especially during crisis situations, i.e., suicidal acting out.

Furthermore, project staff have been involved at the Cornwells Heights facility in working with cases they believe to have been inappropriately sent to their agency. In these situations, a full evaluation is performed and alternative placements explored.

Lastly, both formal and informal staff consultation is provided on a daily basis by this project to line personnel at both Youth Development Centers.

Community Liaison

A multitude of area agencies that serve adolescents have been contacted by project personnel. A resource list has been compiled in order that staff will have for future use a readily available directory of various agencies which provide such services as MH/MR treatment, housing, rehabilitation, planning services, legal assistance, financial aid, and other help to adjudicated adolescents.

Research

Project staff have been reviewing the psychiatric, psychological, and sociological literature in order to develop a model for classifying the Youth Development Center population according to delinquent, dependent, and psychopathological trends. Outcome studies pertaining to the treatment of this population have also been perused and organized into a resource file.

Program Planning

Plans have been developed and are ready to be implemented for establishing a transitional program at the Cornwells Heights Youth Development Center. Adolescents who have an MH/MR disability will be referred to project staff approximately several months prior to their discharge. They will be enrolled in pre-release, reality oriented. Counseling groups and in designated cases, full evaluations will be performed to assist in discharge planning. If the youngster is to return home, every effort will be made to prepare the family for this through family counseling sessions while the adolescent is still incarcerated. If the individual instead is to go to an agency, project staff will be available to that agency to help them with the adolescent's overall adjustment. In this manner, follow-up and continuity of care will be maintained in these at-risk cases.

Project Staff Complement

Job descriptions of the key Project personnel are as follows:

1. Program Administrator

   This staff member is responsible for the overall administration, supervision and coordination of the Project. His duties

include arranging staff meetings, assuring continuous communication between different segments of the Project; arranging staff scheduling and availability; facilitating fiscal accountability and management; supervising the administrative staff; maintaining effective liaison between service delivery sites and between the Project and other relevant organizations and agencies; monitoring the Project Plan and timetable to assure that the goals and objectives are being met as scheduled; coordinating efforts to remove Project obstacles as identifed by the staff.

2. Psychiatrist and Resident

Provide comprehensive diagnostic services required by client identification from the target population; provide individual, group and family counseling when indicated; advise YDC personnel in the implementation and development of the service plan and case management; provide in-service training in mental health methods and treatment; assist in identifying and utilizing appropriate alternative placements; evaluate and assess the current treatment system, and recommend needed changes.

3. Psychologist

Provide services involving all necessary psychometric testing instruments; assist in developing client treatment plans; provide staff consultation and training; assist in developing alternative resources.

4. Social Worker

Provide individual and group counseling; develop social analyses and determine environmental factors; assist in the development of treatment plans; work as a liaison with other social agencies and assist in securing supplemental services and alternative placements.

5. Family Therapist

Perform in-depth family diagnoses; when the prognosis involves return to the home, assist the family in implementing the case plan; assist in diagnosis, service planning, case management, and alternative placement.

6. Research Associate

Collect and analyze all Project data; determine the extent and incidence of mental health problems and service needs in the relevant YDC's; study and provide analysis of the diagnostic procedures employed by the Project; develop assessments and measuring instruments for the Project and design and implement an evaluation process; arrange planning for a future independent evaluation; compare Project performance to those efforts in other states and counties, and assist in the development of a state-wide planning model.

Appendix G

GOVERNOR'S TASK FORCE ON MENTAL HEALTH OF JUVENILE OFFENDERS

Distribution List A
(Copies of all Information)

Task Force Members

Mr. Ricardo W. Coles
Director
Youth Forestry Camp No. 1
Raccoon Creek State Park
R.D. No. 1
Hookstown, Pennsylvania 15050

The Honorable David DiCarlo
House of Representatives
Room 24 7-A, Main Capitol Building
Harrisburg, Pennsylvania 17120

Mrs. Harriet Goldstein, ACSW
Associate Director
Association for Jewish Children of Philadelphia
1301 Spencer Street
Philadelphia, Pennsslvania 1914 1

Clarice Kendall, MSW
Crispus Attucks Center
605 South Duke Street
York, Pennsylvania 174 03

The Honorable Edmund V. Ludwig
Judge, Court of Common Pleas
Court House
Doylestown, Pennsylvania 18901

Ms. MaryEllen McMillen (Chairperson)
Director
Berks County Mental Health Assoc.
54 0 Spruce Street
"K" Building, Reading Hospital
West Reading, Pennsylvania 19602

The Honorable Michael O'Pake
Senate of Pennsylvania
Room 171, Main Capitol Building
Harrisburg, Pennsylvania 17120

Mr. Ernest Powell
Director
Youth Forestry Camp No. 2
Hickory Run State Park
White Haven, Pennsylvania 18661

Mr. Gary Rossman
Penna. Association of County Commissioners
301 Blackstone Building
112 Market Street
Harrisburg, Pennsylvania 17101

Ronald Sharp, Ph.D.
Director
Juvenile Court Judges' Commission
Towne House Apts. — First Floor
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Meyer Sonis, M.D.
Professor —
Child Psychiatrist
Western Psychiatric Institute & Clinic
3811 O'Hara Street
Pittsburgh, Pennsylvania 15213

Robert Switzer, M.D.
Superintendent
Eastern State School & Hospital
374 0 Lincoln Highway
Trevose, Pennsylvania 1904 7

EX-OFFICIO MEMBERS

Mr. Aldo Colautti
Secretary of Public Welfare
Room 333, Health & Welfare Building
Harrisburg, Pa. 17120

Mr. Gerald Gornish
Acting Attorney General
Department of Justice
Capitol Annex — Old Museum Building
Harrisburg, Pa. 17120

Robert M. Daly, M.D.
Deputy Secretary for Mental Health
Department of Public Welfare
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Mr. Gerald Radke
Deputy Secretary for Social Services
Department of Public Welfare
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STAFF LIAISON

Mr. Milton Berks
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DEPARTMENT OF JUSTICE

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Department of Justice
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DPW OFFICE OF CHILDREN AND YOUTH

Mr. Horace Lowell
Youth Program Specialist
Bureau of Youth Programs
Annex 33
Harrisburg State Hospital
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DPW OFFICE OF MENTAL HEALTH

Harold Graff, M.D.
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Mr. Todd Patterson
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GOVERNOR'S TASK FORCE ON MENTAL HEALTH OF JUVENILE OFFENDERS

Distribution List B
(Agenda, Minutes, Reports only)

DPW REGIONAL OFFICES

1 copy to each Regional Deputy Secretary for circulation to the Regional Commissioner for Mental Health and Directors of Child Welfare Services and of Youth Services.

YOUTH FORESTRY CAMPS
and
YOUTH DEVELOPMENT CENTERS

1 copy to Mr. Gerald Radke, Deputy Secretary for Social Services, for circulation to Directors.

ADVISORY COMMITTEE FOR MENTAL HEALTH AND MENTAL RETARDATION

Mr. Gary L. Ellis (Chairperson)
Executive Director
Lancaster Cleft Palate Clinic
24 N. Lime Street
Lancaster, Pa. 17602

(for reporting to the Committee members)

ADVISORY COMMITTEE FOR CHILDREN & YOUTH

1 Copy to Mr. Paul DeMuro for circulation to members.

TASK FORCE ON MENTAL HEALTH PLANNING FOR CHILDREN AND YOUTH

1 Copy to Dr. H. Allen Handford for circulation to members.

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DPW STAFF

SECRETARY'S OFFICE

Ms. Jean Davis
Special Assistant to the Secretary
331 Health & Welfare Building
Harrisburg, Pa. 17120

Mr. John Baer
Public Information
313 Health & Welfare Building
Harrisburg, Pa. 17120

OFFICE OF MENTAL HEALTH

1 copy for circulation to Executive Staff.

OFFICE OF CHILDREN AND YOUTH

1 copy for circulation to staff.

GOVERNOR'S OFFICE

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Executive Secretary
Child Development Committee
900 Market Street
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LEGISLATURE

The Honorable W. Louis Coppersmith
Chairman, Public Health & Welfare Committee
Senate of Pennsylvania
Harrisburg, Pa. 17120

The Honorable Anita P. Kelly
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JUVENILE JUSTICE CENTER OF PENNSYLVANIA

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